Chapter VI

COMPLAINT RECEIPT AND SCREENING: CENTRAL COMPLAINT UNIT

A. General Description of Functions

The Medical Board's Central Complaint Unit (CCU) is responsible for receiving, acknowledging, screening, and processing all complaints and reports the Medical Board receives about the medical care provided by and conduct of California physicians.

CCU is located in Sacramento, and is currently staffed by two managers, 15 analysts, 5 management services technicians, and a number of support staff. None of these staff positions were lost during the state's recent hiring freeze and subsequent vacant position elimination procedure required by the Budget Acts of 2002 and 2003. In addition, CCU is supported by a cadre of physicians under contract with the Unit who review complaints and medical records to assist in determining whether complaints should be referred for formal investigation. As of October 2003, a deputy attorney general from the Health Quality Enforcement Section of the Attorney General's Office and a supervising investigator from MBC's field investigations staff joined CCU; their roles are described below.

CCU processes written complaints and reports received by mail. Most complaints are filed on MBC's complaint form, which is available online[95] or by calling the Board's toll-free complaint line.[96] CCU will occasionally take and transcribe oral complaints of an urgent nature over the telephone. CCU staff are also responsible for answering MBC's complaint line in order to respond to inquiries, mail complaint forms and information, and otherwise direct callers to appropriate locations. Simply put, CCU's complaint processing responsibility requires it to review and analyze incoming complaints and reports, and determine whether each should be closed or forwarded on to one of twelve MBC regional district offices for formal investigation.

[95] Consumers may access MBC's consumer complaint form at www.caldocinfo.ca.gov or www.medbd.ca.gov under "Forms and Publications." The same link provides reporting forms for the "mandated reporters" identified in Business and Professions Code section 800 *et seq*. described below.

[96] MBC's toll-free complaint number is 1-800-633-2322.

CCU Complaint Initiation and Processing. Once a complaint or report is received, it is screened by a senior program analyst to ensure that it contains sufficient information to be processed, and then "initiated" in MBC's automated enforcement tracking system known as CAS (Consumer Affairs System) by a management services technician (MST). The MST assigns the complaint a number, pulls the prior licensing and disciplinary history of the complained-of physician, and enters various types of information about the new complaint, including the following: (1) the kind or category of the allegation;[97] (2) the specialty area of medicine that is the subject of the complaint or report; (3) the date the complaint was received by MBC — this triggers the statute of limitations applicable to the Board;[98] (4) the "investigation type" — that is, whether the complaint has been filed against a Board licensee, a nonlicensee, or a candidate for licensure; (5) the source of complaint or report; (6) the priority assigned to the complaint (see below); (7) the name and address where the incident occurred, if known; and (8) the date of the incident, if known. The MST generates a letter to the complainant acknowledging receipt of the complaint,[99] and transfers the complaint file to one of the staff services analysts (SSAs) for further processing.

The SSA then reads and analyzes the complaint or report, and takes further action based on whether the complaint (1) is "jurisdictional" — that is, within the regulatory scope of the Medical Board; (2) concerns the quality of care provided by the subject physician (for example, a misdiagnosis), or (3) pertains more generally to conduct of the physician rather than the quality of care provided (for example, refusal to provide the patient's medical records to the patient).

If a complaint is "non-jurisdictional," the SSA forwards it to the appropriate agency and/or closes the matter, and informs the complainant. Some complaints are mediable. For example, if a physician refuses to provide medical records to the patient, the SSA may telephone the physician, explain the law, and persuade the physician to turn over the records. In such a matter, the case is closed.

In order to analyze a quality of care (QC) complaint, CCU must procure the medical records of the patient from the complained-of physician (and often other treating physicians and institutions),

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[97] In entering the kind or category of the allegation, the CAS system limits CCU MSTs to generic categories such as "negligence/incompetence," "drug prescribing violation," "unlicensed practice," "sexual misconduct," and "unprofessional conduct."

[98] Subject to specified exemptions, Business and Professions Code section 2230.5 requires MBC to file a formal accusation within three years of the date it discovers the event that is the subject of the complaint, or within seven years after the event — whichever occurs first. MBC regulations define "discovers" to mean "the date the board received a complaint or report describing the act or omission," and "the date, subsequent to the original complaint or report, on which the board became aware of any additional acts or omissions alleged as the ground for disciplinary action against the same individual." 16 CAL. CODE REGS. § 1356.2.

[99] Business and Professions Code section 129(b) requires MBC and other DCA agencies to acknowledge receipt of complaints within ten days.

which are subject to the physician-patient privilege and may not be released by the physician absent the patient's permission. Thus, CCU must secure the signature of the patient on a "release" or waiver of the privilege and request all relevant medical records on the patient, which may include charts, X-rays, laboratory test results, photographs, invoices, and correspondence. CCU may also request that the physician provide a summary or explanation of the care and treatment provided to the patient. Once the SSA receives those medical records and other documents, the entire file is reviewed by one of the CCU's medical consultants — generally Sacramento-area physicians who "triage" QC cases, determine whether there has been a departure from the applicable standard of care, and recommend that the case should be closed (because it reveals no violation or involves conduct that does not merit disciplinary action) or referred to the appropriate regional field office for formal investigation.

Non-quality of care cases may involve alleged sexual misconduct, drug or alcohol abuse, false advertising, fraud, or criminal activity (among others). If the proper analysis of these cases requires the patient's medical records, CCU will secure the waiver, request the records, and turn the matter over to a medical consultant for a recommendation on whether the case should be closed or go forward. If not, CCU will process the case as appropriate depending on the type of case and sufficiency of the evidence.

Pre-2002 CCU Complaint Processing. Prior to mid-2002, CCU's SSAs were generalists who were "tied to" the geographic region served by a particular MBC district office, meaning that a given SSA would be assigned all cases that — if referred for formal investigation — would be transmitted to a particular regional district office. As such, SSAs handled all types of cases, including both QC cases and non-QC cases.

From its inception in 1990, CCU utilized three categories for prioritizing complaints: "urgent," "high," and "routine." Cases classified as "urgent" included allegations of sexual misconduct, self-use of drugs or alcohol, mental illness, physicians terminated from the Board's Diversion Program for substance-abusing physicians, section 805 reports of adverse peer review action by hospitals, felony convictions, unlicensed practice of medicine involving patient harm, coroner's reports of physician negligence resulting in death, and complaints against physicians on probation. Complaints classified as "high priority" included drug prescribing violations, quality of care cases involving a patient death, complaints against physicians currently under investigation, complaints against physicians with multiple prior investigations, criminal conviction cases (other than felonies), certain unlicensed practice of medicine cases, and quality of care cases involving gross negligence or incompetence. Complaints classified as "routine" included allegations of fraud, false advertising, failure to release medical records, failure to sign death certificates, fictitious name permit violations, patient abandonment, workers' compensation complaints, and quality of care/medical malpractice cases that do not pose a danger to public health and safety.

Prior to 2003, CCU was assisted in processing and screening quality of care cases by a group of approximately 12 Sacramento-area physicians, most of whom were in active medical practice. Most of these medical consultants specialized in family practice or internal medicine; a few specialized in obstetrics/gynecology, psychiatry, or ophthalmology. Their role was to (1) review quality of care complaints and the medical records and other information gathered by CCU; (2) summarize (in a written report) the patient's complaint (including relevant patient history) and the subject physician's treatment of the patient; (3) describe the standard of practice for the treatment of such a patient; (4) specifically describe any departures from the described standard of practice by the physician; (5) state their opinion as to whether the overall care of the patient constitutes either no departure from the standard of practice, a "simple departure" from the standard of practice,[100] an "extreme departure" from the standard of practice,[101] or incompetence;[102] and (6) based on their opinion, recommend appropriate disposition of the matter. Generally, medical consultants would stop by CCU once or twice a week, gather new complaint files, and drop off reviewed cases and dictated opinions for transcription. Under this system, it is possible that a complaint involving a neurological procedure might be reviewed by an internist or pediatrician. However, if a medical consultant felt that he or she did not have sufficient relevant expertise to review a particular case, CCU would either refer it to another CCU medical consultant with relevant expertise or refer it to the field so it could be reviewed by a specialist expert reviewer selected by a district office medical consultant.

Certain kinds of complaints and reports were deemed important enough to refer directly to the field without extensive CCU screening. Prior to 2003, those matters included the following: (1) section 805 reports of adverse peer review action against a physician's privileges; (2) reports of drug-related criminal convictions against a physician; (3) complaints of serious sexual misconduct; (4) complaints concerning excessive prescribing (where MBC might want to engage in undercover operations); (5) new complaints against a physician whose license was already on probation; and (6) new complaints against a physician who was already under investigation or against whom an accusation was pending.

Post-2002 CCU Case Processing. During mid-2002, MBC was undergoing sunset review and SB 1950 (Figueroa) was being developed in the Legislature. As described in Chapter IV,[103] the

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[100] CCU's *Medical Consultant Procedure Manual* defines a "simple departure" as conduct that "deviated from the standard of practice but does not warrant further investigation (a single negligent act that is not considered an extreme departure)."

[101] CCU's *Medical Consultant Procedure Manual* provides examples of "extreme departures," as follows: "failure to do basic diagnostic tests, failure to recognize or act upon common symptoms, failure to use accepted effective treatments or diagnostic procedures, using outdated procedures, failure to refer a patient to a specialist when appropriate."

[102] CCU's *Medical Consultant Procedure Manual* defines "incompetence" as "lack of knowledge or ability in carrying out professional medical obligations."

[103] *See supra* Ch. IV.G.

sunset committee's background paper and various amendments to the bill indicated the Legislature's intent that MBC focus its resources first on quality of care matters in which patients have been injured. To implement that legislative intent, MBC enforcement management instituted a number of changes in the way CCU processes complaints and reports on physicians.

■ ***Division of Unit***. During the summer of 2002, CCU was divided into two sections: the Quality of Care (QC) Section and the Physician Conduct (PC) Section. For purposes of case referral, a "quality of care" case is defined as one "directly related to the doctor/patient relationship in which the physician diagnoses and/or provides treatment for a condition, disease, injury or physical or mental condition."[104] In practice, QC cases tend to be those requiring collection of the patient's medical records and review of those records by a physician. "Physician conduct" cases include all other kinds of complaints, including failure to provide adequate treatment due to physician impairment, sexual misconduct, and the provision of an opinion about a patient's condition (for example, evaluations for an injury or disability). Anticipating that it would receive more QC cases than PC cases, CCU allocated seven SSAs to the QC section and six SSAs to the PC section. The QC SSAs are still generally "tied to" specified MBC district offices, while the PC SSAs specialize in certain types of complaints (for example, sexual misconduct, physician impairment, fraud, and complaints against doctors of podiatric medicine).

■ ***Case Processing Priorities***. Effective January 1, 2003, SB 1950 enacted section 2220.05, which declares that "[i]n order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

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[104] Medical Board of California, Central Complaint Unit, *CCICU Procedure Manual* at Ch. 4. The *Manual* illustrates types of cases that should be categorized as QC cases and be referred to the QC Section, including allegations that a diagnosis was incorrect or delayed, the treatment provided was inappropriate for the condition (or no treatment was provided), the treatment was provided in a negligent manner causing harm or injury to the patient, medication prescribed was inappropriate for either the condition or the patient, medication prescribed was inadequate to treat the patient's pain, medication prescribed was excessive, or the physician failed to adequately document the patient's medical record.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. . . .[105]

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(5) Practicing medicine while under the influence of drugs or alcohol."

Thus, as of January 1, 2003, the CCU MSTs initiating complaints into MBC's computer system assign a priority code to each case according to the section 2220.05 priorities. In MBC parlance, section 2220.05 "priority cases" are called "U1" or "U3" or "U5," depending on which subsection of 2220.05(a) is applicable. For cases not falling into a section 2220.05 priority category, CCU continues to utilize the pre-existing prioritization categories of "urgent," "high," and "routine." In addition, U1–U5 priority cases are physically "red-tagged" so that CCU analysts can visually distinguish them from the rest of their caseload.

■ ***"Specialty Reviewer" Requirement***. Also effective January 1, 2003, SB 1950 (Figueroa) added section 2220.08, which prescribes a specific review process for quality of care cases in CCU. The statute requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been "reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." Section 2220.08 specifies that such "specialty review" must include a review of relevant patient records, a statement or explanation of the care and treatment provided by the subject physician, any additional expert testimony or literature provided by the subject physician, and any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care. The "specialty reviewer" requirement does not apply to section 805 reports or to egregious cases in which MBC seeks to obtain an interim suspension order or other emergency relief. It also does not permit subject physicians to endlessly delay referral of a complaint to the field; the statute requires the Board to request the medical records and other materials for review, and provides that if the Board does not receive them within ten days of its request, "the complaint may be reviewed by the medical experts and referred to a field office for investigation without the information."

[105] Business and Professions Code section 2220.05(a)(3) emphasizes that a physician prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing practices shall not be prosecuted for excessive prescribing.

The "specialty reviewer" requirement has required CCU to recruit and train new medical consultants in a number of different specialties and subspecialties so that QC complaints and reports can be reviewed by a physician with relevant expertise. Further, CCU's policy on cases that may be sent directly to the field without extensive CCU processing has been slightly modified. CCU still sends section 805 reports and potential ISO cases directly to the field because they are expressly exempt from section 2220.08's expert reviewer requirement. Additionally, it still sends serious sexual misconduct and excessive prescribing cases to the field because those are not classified as quality of care complaints (to which section 2220.08 applies). However, it does not always send new complaints against a physician whose license is already on probation and new complaints against a physician who is already under investigation or against whom an accusation was pending to the field without specialty review.

Section 2220.08(d) requires the Monitor to recommend "whether a complaint received by the board relating to a physician and surgeon who is the subject of a pending investigation, accusation, or on probation should be reviewed pursuant to this section or referred directly to field investigation." The Monitor agrees with CCU management that such a complaint should be referred directly to the field without specialty review if the investigator investigating the original case (or the probation monitor, or the DAG prosecuting the pending accusation) wants it at that time without specialty review. The investigator, probation monitor, or DAG should be immediately informed of the new complaint and given the option of its immediate referral without specialty review. MBC has been accused of failing to detect patterns and failing to address repeat offenders; if a physician is already under investigation, the subject of a pending accusation, or on probation, the investigator, prosecutor, or probation monitor should receive new complaints as soon as possible so they can be integrated into the existing investigation and/or prosecution.

■ ***Additions to CCU***. Effective October 1, 2003, two persons were newly assigned to CCU. The half-time assignment of an HQE deputy attorney general (DAG) to CCU represents MBC/HQE's long-overdue implementation of SB 2375's requirement that HQE "assign attorneys to assist the division . . . in intake . . . . Attorneys shall be assigned to work closely with each major intake and investigatory unit . . . to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations."[106] At the same time, MBC assigned a Supervising Investigator to work full-time at CCU — such that CCU now has built-in legal and investigative expertise to assist in the processing and review of complaints. Initially, their skills were not well integrated into the Unit. The CCU DAG and Supervising Investigator reviewed only quality of care complaints that

[106] Gov't Code § 12529.5(b); *see also* Ch. IV.C. A brief and limited effort to provide some measure of guidance pursuant to section 12529 was undertaken by HQE in 1991–93. An HQE supervising attorney was assigned to review some of the case closures at CCU during this period, but the experiment was limited in scope and was terminated shortly thereafter.

were proposed for closure without being reviewed by a medical consultant; they reviewed no other QC or PC cases. Additionally, they attempted (on a part-time basis) to reinstitute MBC's undercover Internet Crimes Unit; assisted with reviewing unusual and/or borderline cases; and undertook special tasks such as procedure manual review.

By September 2004, their roles had expanded considerably. The CCU DAG now reviews all medical consultant-reviewed quality of care cases in which a simple departure has been found, and all medical consultant-reviewed cases in which there is a split of opinion between MCs. Additionally, he has become involved in a few cases in which subject physicians or health care institutions have failed to produce requested medical records, and has reviewed and assisted in revising the *CCU Medical Consultant Procedure Manual* and various CCU forms. The CCU Supervising Investigator now reviews quality of care complaints that are proposed for closure without being reviewed by a medical consultant, physician conduct cases being recommended for referral to investigation, and complaints being recommended for closure due to insufficient evidence. In addition, he assists with medical records procurement issues, performs undercover investigations of suspected Internet prescribing violations, serves as a liaison between MBC and other agencies concerning the unlicensed practice of medicine, designs and teaches training courses for CCU analysts, reviews proposed updates to MBC's *Enforcement Operations Manual*, and assists in the recruitment of new medical consultants and expert reviewers.

The CCU DAG and Supervising Investigator have teamed together to tackle other important issues. The Supervising Investigator now investigates the circumstances behind criminal convictions of physicians that have been reported to CCU, works up an investigative file, and refers it to the DAG, who reviews it as would a DIDO DAG before transmitting it to HQE for the filing of an accusation. The CCU DAG and Supervising Investigator have also identified problems in MBC's Citation and Fine Unit and have developed important modifications to the procedures of both CCU and the Citation and Fine Unit that govern the issuance of citations and fines. They now review cases in which either CCU or a district office has determined to issue a citation and/or and fine to ensure that adequate evidence has been gathered to support the issuance of a citation and fine.

Overall, these new "outside" participants have added value to the CCU process of evaluating and screening complaints and reports of physician misconduct. The DAG and Supervising Investigator estimate that, in the ten months they have worked at CCU, they have reviewed 650 cases; in only 12–15% of those cases did they disagree with CCU's recommendation to close a case. In those cases, they recommended further CCU fact-gathering before a closure, and — eventually — only about 3% of the cases that CCU had initially recommended for closure were sent to the field. This result generally supports the conclusion that CCU's complaint processing and decisionmaking are of high quality.

■ ***Review of "Simple Departures."*** During MBC's 2001–02 sunset review, JLSRC staff expressed deep concern that MBC was closing (on grounds of "insufficient evidence") quality of care cases in which a medical consultant had opined that the subject physician had committed a "simple departure" from the standard of care without checking to see whether that physician had been the subject of prior complaints in which other "simple departures" had been found — such that the physician might be disciplined for "repeated negligent acts" under section 2234(c). Effective April 1, 2003, MBC instituted a new procedure for the review of "simple departures" by a senior program analyst and CCU's senior medical consultant. When a medical consultant-reviewed quality of care complaint results in a finding of "simple departure" and is proposed for closure due to "insufficient evidence" (because one act of negligence is not grounds for MBC discipline), the senior program analyst assesses whether the subject physician has a prior complaint history; if so, that history is gathered from CAS and MBC files and is reviewed by the senior CCU medical consultant and the CCU DAG for a recommendation whether the cases should be combined and investigated for repeated negligent acts under section 2234(c).

Detection of Physician Misconduct: Sources of Complaints and Reports. Unlike other occupational licensing agencies, MBC is not solely dependent on consumers for information about physician misconduct. For many years, the California Legislature has mandated that other institutions (including medical malpractice insurance carriers, courts, and hospitals) file reports with MBC about events that may indicate a problem physician. Exhibit VI-A below displays the number of incoming complaints and reports, by source,[107] about California physicians to MBC for the past few years.

Ex. VI-A. Number and Source of Complaints/Reports Received

SOURCE	FY 2000–01	FY 2001–02	FY 2002–03	FY 2003–04
BPC 800 Reports	1,538	1,454	1,385	1,240
Gov't/Law Enforcement Agencies	1,953	1,996	1,737	1,593
Medical Profession	279	264	295	283
Public/Other	4,450	4,845	5,478	5,124
SUBTOTAL	**8,220**	**8,559**	**8,895**	**8,240**
CCP 364.1	2,247	2,244	2,377	2,148
NPDB	432	415	284	273
TOTAL RECEIVED	**10,899**	**11,218**	**11,556**	**10,661**

Source: Medical Board of California

Following is an explanation of the "source" categories included in Exhibit VI-A:

[107] CCU captures the source of all complaints and reports according to 67 different categories. For convenience at this stage of our report, we have collapsed those 67 categories to six; these six source categories are explained in more detail below.

■ **"BPC 800 Reports"** include reports filed with the Medical Board by various "mandated reporter" individuals and institutions under a series of requirements contained in Business and Professions Code section 800 *et seq*., as follows:

- Section 801(b) requires medical malpractice insurers to file a "complete report" with the Medical Board when they pay out on a malpractice settlement over $30,000, an arbitration award of any amount, or a civil judgment of any amount. Additionally, section 803(b) requires malpractice insurers to report to MBC the entry of a civil judgment in any amount in a claim for damages for death or personal injury caused by the insured's negligence, error, omission in practice, or rendering of unauthorized professional services.[108]

- Section 801.1(b) requires state and local government agencies that self-insure physicians (for example, the University of California) to file a "complete report" with MBC when they pay out on a malpractice settlement or arbitration award over $30,000.

- Section 802(b) requires a physician who does not have malpractice insurance to self-report to MBC medical malpractice settlements over $30,000 and arbitration awards of any amount. If the physician does not so report within 45 days, the physician's counsel is required to file the report with MBC.

- Section 802.1 requires a physician to self-report to MBC the filing of felony charges against the physician and the conviction of the physician of any felony (including any guilty verdict or plea of guilty or no contest).

- Section 802.5 requires a coroner to file a report with MBC whenever the coroner performs an autopsy or otherwise "receives information" from a board-certified pathologist indicating that a death may be the result of a physician's gross negligence or incompetence.

- Section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC.

- Section 803.2 requires "employers" (including professional corporations, medical groups, health care facilities, and HMOs) of physicians who agree to pay judgments

[108] Additionally, Business and Professions Code section 804(d) requires insurers and other specified mandated reporters to maintain for one year all written patient medical or hospital records, depositions, and other discovery generated during the civil action that led to the settlement or other event being reported to MBC.

or arbitration awards in any amount and settlements of $30,000 or more on behalf of a physician to report that physician to MBC. The report must include the name and license number of the physician.

- Section 803.5(a) and (b) require prosecutors and court clerks to notify MBC of any felony criminal filings against a physician "immediately upon obtaining information that the defendant is a licensee of the board." Section 803.5 also requires the prosecutor to notify the court clerk that the defendant is a physician, and "the clerk shall record prominently in the file that the defendant holds a license" from MBC. Section 803.6 requires the clerk of the court in which a physician has been charged with a felony to transmit any felony preliminary hearing transcripts concerning the physician to MBC. Section 803.5(b) requires the clerk of the court in which a physician is convicted of any crime to, "within 48 hours after the conviction, transmit a certified copy of the record of conviction" to MBC.

- Section 805 requires hospitals and HMOs to report to MBC the denial, termination, or revocation of a physician's staff privileges for "medical disciplinary cause or reason." In addition, hospitals and HMOs are required to file a "section 805 report" when (a) "restrictions [on staff privileges] are imposed, or voluntarily accepted . . . for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason," (b) staff privileges are summarily suspended, if the suspension remains in effect for a period in excess of 14 days; and (c) any of the following occur after the physician learns of either an impending investigation or the denial or rejection of the application for staff privileges for a medical disciplinary cause or reason: (1) the physician resigns or takes a leave of absence from his/her staff privileges; (2) the physician withdraws or abandons an application for privileges; and (3) the physician withdraws or abandons an application for renewal of those privileges.

■ **"Government/Law Enforcement Agencies"** may also file and/or refer complaints and reports to MBC. These may include agencies of the federal government (such as the U.S. Drug Enforcement Administration, the Food and Drug Administration, or the Department of Health and Human Services), medical and other health care licensing boards from other states, other California agencies (including the state Department of Health Services, Department of Managed Health Care, the Department of Consumer Affairs and its constituent agencies, and the "Criminal Identification and Information" (CII) system of the Attorney General's Office, which contains fingerprints of all licensed physicians and notifies MBC whenever any of them have been arrested), and local law enforcement entities (such as district attorneys' offices and local police or sheriff departments).

■ **"Medical Profession"** includes complaints filed against physicians by physicians, other healing arts licensees, and physician professional organizations and medical societies.

■ **"Public/Other"** includes complaints filed by patients and their family members, friends, or advocates (for example, attorneys and clergy members), pharmacists, consumer groups, employees or co-workers of the complained-of physician, and confidential informants. MBC accepts anonymous complaints.

■ **"CCP 364.1"** stands for section 364.1 of the California Code of Civil Procedure (CCP). CCP section 364 precludes any person from filing a medical malpractice action against a "health care provider" (including a physician) unless he first provides at least 90 days' notice to the physician; the "notice of intent" (NOI) must "notify the defendant of the legal basis of the claim and the type of loss sustained, including with specificity the nature of the injuries suffered." CCP section 364.1 requires the plaintiff to send a copy of the 90-day NOI required by section 364 to the Medical Board, ostensibly to alert MBC that a civil malpractice action may soon be filed against one of its licensees.

■ **"NPDB"** is the acronym for the National Practitioner Data Bank maintained by the U.S. Department of Health and Human Services' Health Resources and Services Administration. Since 1990, NPDB has received reports of and maintained records on licensure and disciplinary actions by state medical boards, malpractice payouts by insurance carriers, and hospital disciplinary actions against physicians licensed in all 50 states. Respectively, state medical boards, insurance companies, and hospitals generally check with the NPDB before licensing, insuring, or granting privileges to a physician. The concept behind the NPDB is to prevent problem physicians from moving from state to state and gaining licensure and other privileges by lying about their past. The NPDB's records are not available to the public. However, they are available to the Medical Board, and MBC receives a copy of reports filed with the NPDB by insurers when they pay out on a reportable settlement, judgment, or arbitration award.

Sources of Complaints Resulting in Investigation and Prosecution. Exhibit VI-B below presents a breakdown of all complaints received by MBC in 2003–04, by referral source, and the percentage of complaints submitted by each source that were referred for investigation and prosecution (either by HQE or by local prosecutors).

We can draw several conclusions from these data. First, the predominant source of complaints is patients, their advocates, and their families. However, those complaints are rarely referred for investigation — only 9% of patient complaints went to investigation during 2003–04 (which is consistent with 2002–03, in which 11% of patient complaints were referred for investigation). The principal sources of complaints referred for investigation were mandatory reports required by Business and Professions Code section 800 *et seq*., especially section 805 reports of

adverse peer review action taken by hospitals (73% of section 805 reports were referred for investigation), section 802.5 reports by coroners (45% referred), section 803/803.5 reports by court clerks of physician criminal convictions and civil judgments (31% referred), section 801/801.1/803.2 reports by insurers and employers of malpractice payouts (24% referred), and section 802/802.1 self-reporting by physicians (22% referred). Other high-yield sources are medical and osteopath boards in other states, other government agencies, and local police or sheriff departments.

Ex. VI-B. FY 2003–04 Physician Complaint Processing and Investigations By Referral Source

Referral Source	FY 2003–04								
	Complaints Received	Reviewed By Medical Consultant	Complaints Closed By CCU	Referred to Investigation		Non-Legal Closures	Legal Closures		
				Number	Percent		Attorney General*	District Attorney*	Percent
Patient, Patient Advocate, Family Member or Friend	4,516	1,245	4,368	441	9%	420	121	12	24%
Out of State Medical/Osteopathic Boards	375	1	289	83	22%	6	77	0	93%
Section 801, 801.1 & 803.2 (Insurers & Employers)	797	620	624	194	24%	148	54	1	27%
Section 805 (Health Facilities)	157	0	44	120	73%	76	46	1	38%
Department of Health Services	99	27	74	36	33%	32	27	0	46%
M.D. Licensees	243	11	219	52	19%	34	21	1	39%
DOJ - Criminal Identification & Information Bureau (CII)	230	0	238	63	21%	26	29	0	53%
Other Governmental Agencies	91	14	65	30	32%	24	12	0	33%
Anonymous	325	3	296	58	16%	57	14	0	20%
Insurance Company	61	13	56	25	31%	16	8	2	38%
Police/Sheriff Departments	31	1	12	19	61%	16	5	0	24%
Section 802 & 802.1 (Self-Reporting)	228	159	170	47	22%	48	6	0	11%
Other	110	2	97	28	22%	25	4	2	19%
Newsclipping	12	1	6	8	57%	4	3	0	43%
Section 803 & 803.5 (Courts)	20	4	18	8	31%	3	5	0	63%
Employee or Co-worker of Subject	47	1	34	12	26%	8	4	1	38%
Pharmacist or Employee	17	1	14	9	39%	6	3	0	33%
Attorney General & Dept. of Justice	11	2	6	7	54%	2	4	0	67%
Coroner (including Section 802.5)	22	12	12	10	45%	7	4	0	36%
Confidential Informant	18	2	13	8	38%	5	0	0	0%
B&P 2240(A) - Self-Reported Surgical Complications	14	5	8	3	27%	2	2	0	50%
District Attorney	7	1	5	3	38%	2	0	0	0%
Allied Health Licensee	8	0	7	0	0%	1	0	0	0%
Other DCA Boards and Bureaus	45	2	29	4	12%	4	0	0	0%
Other Healing Arts Licensee	15	0	13	5	28%	3	0	2	40%
Hospital (Non-805 Report)	13	0	7	2	22%	1	0	0	0%
Jury Verdict Weekly	2	1	3	0	0%	0	1	0	100%
Court Clerk - Non-Felony Conviction	8	0	9	1	10%	0	1	0	100%
WE Tip	23	0	26	1	4%	1	0	0	0%
Medical Society or Association	6	1	7	1	13%	1	0	0	0%
Total, Excluding Medical Board	7,551	2,129	6,769	1,278	16%	978	451	22	33%
Medical Board	689	19	75	612	89%	541	129	15	21%
Total, Including Medical Board	8,240	2,148	6,844	1,890	22%	1,519	580	37	29%
National Practitioner Data Bank (NPDB) Reports	273	0	273	0	0%	0	0	0	0%
Notice of Intent (NOI) Reports (CCP 364.1)	2,148	0	2,148	0	0%	0	0	0	0%

* May include dual referrals.
Source: Medical Board of California

Sources of Section 2220.05 Priority Complaints. Exhibit VI-C below presents a breakdown of all complaints received in 2003–04 by priority and by referral source. This chart notes the priorities assigned to incoming complaints — both section 2220.05 priority cases (U1–U5) and MBC's "urgent/high/routine" prioritization of cases that do not fall within any U1–U5 category.

Ex. VI-C. FY 2003–04 Physician Complaints Received By Priority By Referral Source

Referral Source	U1 Death or Serious Injury	U3 Excessive Prescribing	U4 Sexual Misconduct	U5 Prctng. Under the Influence	Subtotal Priority U1–U5	Urgent	High	Routine	Total
Patient, Patient Advocate, Family Member or Friend	822	99	74	4	999	425	803	2,290	4,517
Section 801, 801.1 & 803.2 (Insurers & Employers)	772		5		777	10	7	3	797
Section 802 & 802.1 (Self-Reporting)	217	1			218	3	3	4	228
Anonymous	19	28	5	15	67	82	20	156	325
M.D. Licensees	14	14	2	2	32	46	14	151	243
Department of Health Services	19	6			25	22	18	34	99
Coroner (including Section 802.5)	16				16		2	4	22
Police/Sheriff Departments		3	9	1	13	9	3	6	31
Other Governmental Agencies	8	4	1		13	22	10	47	92
B&P 2240(A) - Self-Reported Surgical Complications	13				13	1			14
Employee or Co-worker of Subject	2	3	3	2	10	11	1	25	47
Section 803 & 803.5 (Courts)	3				3	8	7	2	20
Section 805 (Health Facilities)	3		2	2	7	127	12	11	157
Insurance Company	2	5			7	14		40	61
Attorney General & Department of Justice	4	1			5	1	2	3	11
Pharmacist or Employee		5			5	4	1	7	17
Other	3	1	1		5	22	1	82	110
Out of State Medical/Osteopathic Boards	3	1			4			371	375
Newsclipping	3				3	5		4	12
Confidential Informant	1	1		1	3	8		7	18
Other Healing Arts Licensee		2			2	2	1	10	15
WE Tip		2			2	3		18	23
Other DCA Boards and Bureaus	1	1			2	21	4	17	44
District Attorney					0	5		2	7
DOJ-Criminal Identification & Information Bureau (CII)					0	45	180	5	230
Allied Health Licensee					0	1	1	6	8
Medical Society or Association					0			6	6
Hospital (Non-805 Report)					0	4	2	7	13
Court Clerk - Non-Felony Conviction					0		7	1	8
Jury Verdict Weekly					0			2	2
Total, Excluding Medical Board	1,925	177	102	27	2,231	901	1,099	3,321	7,552
Medical Board	82	23	12	1	118	86	22	462	688
Total, Including Medical Board	2,007	200	114	28	2,349	987	1,121	3,783	8,240
National Practitioner Data Bank (NPDB) Reports								273	273
Notice of Intent (NOI) Reports (CCP 364.1)								2,148	2,148

Source: Medical Board of California

Exhibit VI-C reveals that of 8,240 complaints received, 2,349 (28%) were assigned a section 2220.05 U1–U5 priority — and 2,007 of the 2,349 priority cases were assigned a U1 priority (85%). The clear majority of the complaints received by MBC in 2003–04 (72%) did not fall into any U1–U5 priority category. Note also that no case was categorized as a section 2220.05 U2 priority ("drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient"). These issues are discussed below in Chapter VI.B.

QC vs. PC Complaint Processing. Exhibits VI-D and VI-E below illustrate MBC's processing of quality of care and non-quality of care complaints in calendar year 2003 (the first full year of the restructured Central Complaint Unit, and the first full year of the section 2220.05 priorities) and in fiscal year 2003–04.

Ex. VI-D. Quality of Care Complaint Processing By CCU By Referral Source

Referral Source	CY 2003					FY 2003/04					Average
	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	
Patient, Patient Advocate, Family Member or	2,096	1,280	1,702	365	18%	2,058	1,201	1,816	322	15%	16%
Section 801, 801.1 & 803.2 (Insurers &	851	552	552	207	27%	791	620	617	196	24%	26%
Section 805 (Health Facilities)	111	0	30	76	72%	103	0	23	84	79%	75%
Section 802 & 802.1 (Self-Reporting)	227	173	154	46	23%	219	159	170	38	18%	21%
Out of State Medical/Osteopathic Boards	20	0	7	13	65%	63	1	27	33	55%	60%
Department of Health Services	45	26	22	19	46%	52	23	28	25	47%	47%
M.D. Licensees	53	9	31	15	33%	46	9	27	24	47%	40%
Anonymous	46	1	27	16	37%	81	2	61	14	19%	28%
Insurance Company	24	14	5	10	67%	9	9	8	12	60%	63%
Coroner (including Section 802.5)	15	13	8	9	53%	18	12	9	10	53%	53%
Other Governmental Agencies	22	6	16	10	38%	22	6	13	8	38%	38%
Pharmacist or Employee	10	1	2	7	78%	7	1	4	7	64%	71%
Newsclipping	9	1	3	4	57%	5	1	3	4	57%	57%
Other	5	0	2	2	50%	8	1	3	4	57%	54%
Attorney General & Dept. of Justice	3	4	2	1	33%	5	2	1	4	80%	57%
Police/Sheriff Departments	8	1	3	5	63%	7	1	3	3	50%	56%
B&P 2240(A) - Self-Reported Surgical	9	5	5	2	29%	14	5	8	3	27%	28%
Employee or Co-worker of Subject	5	1	4	2	33%	7	0	2	3	60%	47%
Section 803 & 803.5 (Courts)	9	8	9	2	18%	3	4	6	0	0%	9%
Other DCA Boards and Bureaus	10	1	6	2	25%	7	2	4	2	33%	29%
Confidential Informant	4	3	5	1	17%	3	2	2	2	50%	33%
WE Tip	7	0	6	2	25%	2	0	2	1	33%	29%
Other Healing Arts Licensee	5	1	4	1	20%	3	0	3	1	25%	23%
Hospital (Non-805 Report)	2	0	1	0	0%	6	0	1	1	50%	25%
Allied Health Licensee	2	0	3	1	25%	2	0	1	0	0%	13%
Jury Verdict Weekly	2	0	2	1	33%	1	0	1	0	0%	17%
Medical Society or Association	2	2	3	0	0%	0	1	1	0	0%	0%
District Attorney	1	1	1	0	0%	1	1	1	0	0%	0%
Total, Excluding Medical Board	3,603	2,103	2,615	819	24%	3,543	2,063	2,845	801	22%	23%
Medical Board	179	21	37	140	79%	138	19	34	107	76%	77%
Total, Including Medical Board	3,782	2,124	2,652	959	27%	3,681	2,082	2,879	908	24%	25%
National Practitioner Data Bank (NPDB)	304	0	306	0	0%	273	0	273	0	0%	0%
Notice of Intent (NOI) Reports (CCP 364.1)	2,365	0	2,321	0	0%	2,148	0	2,148	0	0%	0%

Source: Medical Board of California

Ex. VI-E. Non-Quality of Care Complaint Processing By CCU By Referral Source

Referral Source	CY 2003					FY 2003/04					Average
	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	Received	Reviewed by Consultant	Closed	Referred to Investigation	Percent Referred	
Patient, Patient Advocate, Family Member or Friend	2,555	75	2,519	147	6%	2,458	44	2,553	119	4%	5%
DOJ - Criminal Identification & Information Bureau	232	0	217	59	21%	230	0	238	63	21%	21%
Out of State Medical/Osteopathic Boards	298	0	227	50	18%	312	0	262	50	16%	17%
Anonymous	281	1	195	54	22%	244	1	235	44	16%	19%
Section 805 (Health Facilities)	55	0	17	38	69%	54	0	21	36	63%	66%
M.D. Licensees	198	2	167	20	11%	197	2	192	28	13%	12%
Other	103	3	93	5	5%	101	0	94	24	20%	13%
Other Governmental Agencies	68	9	36	20	36%	70	9	51	22	30%	33%
Police/Sheriff Departments	22	0	7	15	68%	24	0	9	16	64%	66%
Insurance Company	72	5	54	16	23%	52	4	48	13	21%	22%
Department of Health Services	56	6	44	16	27%	47	4	46	11	19%	23%
Employee or Co-worker of Subject	39	1	25	8	24%	40	1	32	9	22%	23%
Section 801, 801.1 & 803.2 (Insurers & Employers)	13	0	13	0	0%	6	0	7	9	56%	28%
Confidential Informant	14	0	7	5	42%	15	0	11	6	35%	38%
Section 803 & 803.5 (Courts)	13	0	9	4	31%	17	0	12	6	33%	32%
Other Healing Arts Licensee	16	0	12	5	29%	12	0	10	4	29%	29%
Newsclipping	5	0	1	5	83%	7	0	3	4	57%	70%
Attorney General & Dept. of Justice	6	0	6	5	45%	6	0	5	3	38%	41%
District Attorney	5	0	3	2	40%	6	0	4	3	43%	41%
Other DCA Boards and Bureaus	17	1	13	3	19%	38	0	25	2	7%	13%
Pharmacist or Employee	9	0	9	0	0%	10	0	10	2	17%	8%
Court Clerk - Non-Felony Conviction	8	0	9	1	10%	8	0	9	1	10%	10%
Medical Society or Association	8	0	5	1	17%	6	0	6	1	14%	15%
Hospital (Non-805 Report)	7	0	5	1	17%	7	0	6	1	14%	15%
WE Tip	18	0	15	14	48%	21	0	24	0	0%	24%
Section 802 & 802.1 (Self-Reporting)	6	0	0	6	100%	9	0	0	0	0%	50%
Allied Health Licensee	7	0	5	1	17%	6	0	6	0	0%	8%
Coroner (non-Section 802.5)	1	0	2	0	0%	4	0	3	0	0%	0%
Jury Verdict Weekly	1	1	1	0	0%	1	1	2	0	0%	0%
Total, Excluding Medical Board	4,133	104	3,716	501	12%	4,008	66	3,924	477	11%	11%
Medical Board	573	0	28	536	95%	551	0	41	505	92%	94%
Total, Including Medical Board	4,706	104	3,744	1,037	22%	4,559	66	3,965	982	20%	21%

Source: Medical Board of California

As reflected in the exhibits above, during calendar year 2003 CCU received 3,782 QC complaints and 4,706 PC complaints. These numbers conflict with the assumption upon which CCU section staffing was premised — that MBC would receive more QC complaints than PC complaints. This trend continued in fiscal year 2003–04, during which time CCU received 3,681 QC complaints and 4,559 PC complaints.

Disciplinary Actions Taken in Section 2220.05 Priority Cases. The statute creating the MBC Enforcement Monitor position requires the Monitor to "assess . . . the relative value to the board of various sources of complaints or information available to the board about licensees in identifying licensees who practice substandard care causing serious patient harm . . . ."[109] In this initial report, the Monitor is required to present "an analysis of the sources of information that resulted in each disciplinary action imposed since January 1, 2003, involving priority cases, as

[109] Bus. & Prof. Code § 2220.1(c)(2).

defined in Section 2220.05."[110] Exhibit VI-F below includes information on MBC disciplinary actions taken during that timeframe. The exhibit provides the total number of disciplinary actions taken in both section 2220.05 priority categories and in MBC's pre-existing "urgent/high/routine" categories which are still used to prioritize cases not falling within section 2220.05; it also provides a breakdown for each specific type of disciplinary action (*e.g.*, revocation, surrender, probation with suspension, etc.).

It is important to note that many of the disciplinary actions taken during the 18-month period that the Monitor was required to examine resulted from complaints filed well before the January 1, 2003 effective date of section 2220.05, and most of them were referred for investigation under MBC's pre-existing priority system before that date as well. To accommodate and meet the legislative mandate, MBC staff compiled all disciplinary actions taken during this timeframe and — in hindsight — assigned section 2220.05 codes to them as appropriate so the Monitor could submit this required information.

The data in Exhibit VI-F are susceptible of several conclusions which require explanation. The most fruitful source of complaints in which disciplinary action was taken during this timeframe was out-of-state medical boards and osteopathic medical boards. Twenty-two percent (22%) of the 482 disciplinary actions taken by MBC resulted from out-of-state disciplinary action. However, none of these cases was classified as a section 2220.05 priority case. This is a function of the way MBC codes incoming reports of out-of-state physician discipline. Even though many out-of-state disciplinary actions upon which MBC's subsequent disciplinary action was premised involved "death or serious bodily injury" to a patient (such that they conceivably could have been classified as U1 priorities), technically MBC is not reopening that case, rehearing the evidence, and taking disciplinary action for that death or serious bodily injury — instead, it is basing its own disciplinary action on the other state's disciplinary action.[111] As such, all 109 cases were coded as "routine." Although MBC might have coded those out-of-state disciplines involving death or injury as U1 in order to "pad" its statistics, it did not. This decision is probably appropriate. Many of the physicians disciplined in this category do not reside in California and pose little threat to California consumers; they reside in another state (where they committed the act resulting in discipline) but also have a California license.

The Business and Professions Code section 800 *et seq*. "mandatory reporting statutes" continue to be high-yield sources of information leading to disciplinary actions in priority cases. Of the 114 disciplinary actions taken in section 2220.05 priority cases, 29% resulted from mandatory reporting. This is consistent with the data in Exhibit VI-B above.

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[110] *Id*. at § 2220.1(d).

[111] *See id*. at § 2305 (most disciplinary actions taken by another state or jurisdiction are grounds for disciplinary action in California).

Ex. VI-F. Disciplinary Actions By Referral Source By Priority
January 1, 2003 through June 30, 2004

Referral Source	Total Disciplinary Actions			Revocation			Surrender			Probation with Suspension			Suspension Only			Probation Only			Public Reprimand/PLR			Other Actions		
	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total	B&P 2220.05 Priorities	Other Priorities	Total
Out of State Medical/Osteopathic Boards	-	109	109	-	25	25	-	27	27	-	-	-	-	-	-	-	20	20	-	30	30	-	7	7
Medical Board	15	69	84	2	9	11	4	15	19	2	4	6	-	-	-	7	31	38	-	4	4	-	6	6
Patient, Patient Advocate, or Family Member	24	44	68	1	2	3	6	4	10	3	6	9	-	-	-	6	9	15	5	13	18	3	10	13
B&P 805 Reports (Health Care Facilities)	17	27	44	-	-	-	-	9	9	4	-	4	-	-	-	8	8	16	2	7	9	3	3	6
B&P 801 Reports (Insurers)	14	23	37	-	1	1	-	3	3	-	-	-	-	1	1	6	10	16	4	4	8	4	4	8
Department of Health Services	5	20	25	-	1	1	1	4	5	-	5	5	-	-	-	2	8	10	1	1	2	1	1	2
Other	7	10	17	1	2	3	3	4	7	-	1	1	1	-	1	1	2	3	1	-	1	-	1	1
M.D. Licensee and Medical Society or Association	4	13	17	1	2	3	-	1	1	2	2	4	-	-	-	-	4	4	1	2	3	-	2	2
Other Governmental Agencies	3	12	15	1	-	1	-	4	4	-	3	3	-	-	-	2	4	6	1	-	1	-	-	-
Anonymous	5	7	12	-	-	-	-	2	2	2	1	3	-	-	-	2	2	4	1	-	1	-	2	2
Insurance Company	3	8	11	-	2	2	3	1	4	-	2	2	-	-	-	-	2	2	-	-	-	-	1	1
B&P 802 Reports (Self-Reports)	2	8	10	1	1	2	-	-	-	-	4	4	-	-	-	-	2	2	1	1	2	-	-	-
Police/Sheriffs Department	6	3	9	-	-	-	3	-	3	1	1	2	-	-	-	2	1	3	-	1	1	-	-	-
DOJ Criminal Identification & Information (CII)	-	8	8	-	2	2	-	2	2	-	-	-	-	-	-	-	2	2	-	1	1	-	1	1
Drug Enforcement Administration	4	2	6	1	-	1	2	1	3	-	-	-	-	1	1	1	-	1	-	-	-	-	-	-
B&P 803 Reports (Criminal Charge/Convictions)	1	3	4	-	-	-	-	2	2	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-
District Attorney	2	1	3	1	1	2	1	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Pharmacist or Employee	2	1	3	-	-	-	1	-	1	-	-	-	-	-	-	1	1	2	-	-	-	-	-	-
Total	114	366	482	8	49	57	24	79	103	14	29	43	1	2	3	36	107	145	18	64	82	11	38	49

Source: Medical Board of California

The Medical Board itself was the second most productive source of complaints leading to all disciplinary actions during the 18-month period. The Medical Board is considered the "source" of complaints leading to disciplinary action in a number of different scenarios: (1) CCU or a district office investigator is investigating a case against Dr. X, obtains medical records and — based on the records — realizes that Dr. Y is equally or more culpable, and initiates a complaint against Dr. Y; (2) when an investigator is looking into a case, she will often run a "Civil Index" check (a check on all civil malpractice actions filed against the subject physician) and may find additional victims of the subject physician who have not filed a complaint with MBC, whereupon the investigator will initiate a new complaint against that physician; (3) if a physician whose license is on probation violates the terms of that probation and MBC files a petition to revoke the probation, MBC is listed as the source of the complaint leading to the petition; (4) when a physician whose license has been revoked petitions for reinstatement of his license, the physician's post-revocation conduct and rehabilitation is the subject of an investigation by a district office investigator, and MBC is listed as the source of that investigation; (5) when a self-referred participant in the Diversion Program is terminated for failure to comply with his/her Diversion contract, MBC is listed as the source of that action; (6) if a physician who is on probation decides to simply surrender his/her license, MBC is listed as the source of that surrender; and (7) occasionally, when MBC is investigating an allegation of unlicensed practice, it finds a physician who is aiding and abetting the unlicensed practice and initiates a complaint against that physician.

Of the 482 disciplinary actions taken during this 18-month period, 114 (23%) were taken in section 2220.05 priority cases, and 368 (76%) were taken in nonpriority cases. However, this does not support a conclusion that 76% of MBC's disciplinary actions were taken in cases where "there was no patient harm." As noted above, many of the 109 out-of-state disciplinary actions by other medical and osteopathic boards (upon which MBC took disciplinary action) involved patient harm; yet those were coded as nonpriority. Many of the disciplinary actions in which MBC was the "source" involve physicians whose licenses were revoked or were on probation, and the underlying matters involved patient harm; but the follow-up petition for reinstatement or petition to revoke probation was coded as "routine" rather than as a U1–U5 priority.

Finally, it should be pointed out that this analysis may be premature. As noted above, many disciplinary actions taken between January 1, 2003 and June 30, 2004 resulted from complaints filed and referred for investigation well before January 1, 2003 — before the effective date of the section 2220.05 priorities. It may well be that some complaints referred for investigation then would not be referred today — including complaints about fraud and unlicensed practice.

A Note on the Medical Marijuana Issue. The Monitor has received several letters, emails, and telephone calls from physicians who recommend medical marijuana under the Compassionate Use Act of 1996. Although the number of physicians involved is quite small and the issue is fairly narrow compared to the more global task of the Monitor in evaluating the entirety of MBC's enforcement program, it deserves comment.

The Compassionate Use Act, which was added to California law by Proposition 215 and is codified at Health and Safety Code section 11362.5, provides that "seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."[112] The Act also states that "no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."[113]

The Compassionate Use Act reflects one of the most controversial social-legal-political-health issues in society today. It has spawned numerous lawsuits in both state and federal courts — many of which are still working their way through the judicial system such that they remain unresolved. The federal government does not recognize California's Compassionate Use Act or the medical use of marijuana, which it still classifies as a Schedule 1 drug — meaning it has no medicinal value.

Nonetheless, the Act is the law in California, and it prohibits MBC from disciplining physicians "for having recommended marijuana to a patient for medical purposes." Since the Act became effective, four physicians who recommend medical marijuana have been disciplined. These physicians contend that MBC has violated the Compassionate Use Act in letter and in spirit both by disciplining them and by selectively and unfairly "targeting" them for investigation and prosecution. They have convened an organization of like-minded physicians and patients who have maintained an active presence at all DMQ and MBC meetings for the past three years.

In presentations at public MBC meetings observed by the Monitor over the past few years, and in public administrative and court filings, the medical marijuana advocates consistently press several themes. Their complaints — and MBC's responses to them — include the following:

(1) "Only a handful of physicians, less than twenty, recommend medical marijuana, and MBC has investigated or taken disciplinary action against most them." According to MBC, it has received 14 complaints regarding physician recommendation of medical marijuana since 1997. It investigated eight of them. It has taken disciplinary action in four of them, and one case under investigation is pending. The rest have been closed without investigation or disciplinary action.[114]

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[112] Health and Safety Code § 11362.5(b)(1)(A).

[113] *Id*. at § 11362.5(c).

[114] Medical Board of California, Letter to Honorable Wilma Chan, Chair, Joint Legislative Audit Committee (Aug. 9, 2004) at Attachment 3 (Medical Marijuana Investigations). As noted in Chapter V.B., MBC's computer system requires it to code incoming complaints very generically, with labels such as "negligence/incompetence," "drug

(2) "Investigation and prosecution of physicians for recommending medical marijuana is not among the section 2220.05 mandatory case processing priorities established in SB 1950 (Figueroa)." In response, MBC cites section 2220.05(a)(3), which classifies as a "priority complaint" one that alleges "[r]epeated acts of prescribing . . . controlled substances without a good faith prior examination of the patient and medical reason therefor." According to MBC, it "has implemented this statutory directive and applies it evenhandedly, whether the drug prescribed is Vicodin, Viagra, or medical marijuana."[115] Regardless, section 2220.05 does not preclude MBC from investigating or taking disciplinary action in complaints that do not fall within the ambit of section 2220.05.

(3) "The Board inappropriately and disproportionately responds to complaints from law enforcement authorities about doctors who recommend medical marijuana, when no patient has filed a complaint about any doctor who recommends medical marijuana." According to MBC, law enforcement authorities were the sole source of six of the 14 complaints, and were one of several sources in two others. The sources of the other six complaints were spouses, parents, and/or teachers of the patient to whom medical marijuana had been recommended, and colleague physicians of the doctor who recommended medical marijuana. According to MBC, patients rarely complain about physicians who prescribe drugs for them (even excessively), and the mere fact that "law enforcement" is the source of a complaint does not make the source somehow suspicious or untrustworthy.

(4) "The statute says: '*Notwithstanding any other provision of law*, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes' (emphasis added). The 'notwithstanding any other provision of law' language confers absolute immunity on doctors for their actions related to recommending or approving medical marijuana. Whether such doctors accompany a medical marijuana recommendation with the conduct that would ordinarily accompany the prescription or recommendation of any medication (such as a good faith prior examination of the patient) is legally irrelevant, because all such conduct is absolutely immunized under the Compassionate Use Act."[116]

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prescribing violation," and "unprofessional conduct." It does not enable a search for cases by specific type; nor can it perform a "word search" for all cases involving — for example — "medical marijuana." In response to a request by Assemblymember Hannah-Beth Jackson and Senator John Vasconcellos to the Joint Legislative Audit Committee for an audit of MBC's handling of complaints against physicians who recommend medical marijuana, MBC searched its CCU database and canvassed all of its district offices for information on medical marijuana cases in order to produce the data described above.

[115] Medical Board of California, Letter to Honorable Wilma Chan, Chair, Joint Legislative Audit Committee (Aug. 9, 2004).

[116] According to Administrative Law Judge Jonathan Lew, whose proposed decision was adopted by a DMQ panel on March 18, 2004, this legal argument was made by Tod H. Mikuriya, MD, in response to an MBC accusation alleging unprofessional conduct, gross negligence, negligence, and incompetence arising out of his care and treatment of 16 patients to whom he recommended medical marijuana. Proposed Decision in the Matter of the Accusation Against

The Medical Board disagrees with this position — and has done so by way of a published disciplinary decision and a policy statement adopted by the full Board at its May 7, 2004 meeting. In the disciplinary matter, DMQ rejected the "absolute immunity" argument and instead found that the immunity afforded by the statute is conditional, and "does not exempt [physicians who recommend medical marijuana] from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached."[117] In the policy statement (which is posted on MBC's Web site), the full Board affirmed the position taken by DMQ in the disciplinary matter: Physicians who recommend medical marijuana to their patients for a medical condition must use the same accepted standards of medical responsibility as they would in recommending or approving any other medical or prescription drug treatment. Those accepted standards include a history and good faith examination of the patient, development of a treatment plan with objectives, informed consent, periodic review of the treatment's efficacy, consultation as necessary, and proper recordkeeping that supports the decision to recommend the use of medical marijuana.

Recently, the Joint Legislative Audit Committee was asked to initiate an audit of MBC's handling of medical marijuana complaints. After a full investigation and public hearing, the Committee declined the request on August 12, 2004.

It is fair to say that the Medical Board and its enforcement program have struggled with this controversial issue over the years, but it appears to the Monitor that MBC has responded in a constructive way to the difficult legal and policy issues presented. The disciplinary decision and policy statement conform to the Board's "paramount" priority to protect the public, and set forth clear and reasonable standards to which physicians who recommend medical marijuana will be held — standards that are no different from the standards applicable to any physician who recommends or prescribes any medication. The Monitor will continue to observe and evaluate MBC's implementation of its policy statement and its handling of these cases during the second year of the project.

Tod H. Mikuriya, MD, Case No. 12-1999-98783 (Jan. 30, 2004), adopted by the Division of Medical Quality on March 18, 2004. In this decision, DMQ revoked Dr. Mikuriya's license, stayed the revocation, and placed his license on probation for a term of five years subject to a number of terms and conditions. Dr. Mikuriya is challenging this order in court.

[117] *Id.* In so concluding, DMQ agreed with the U.S. Ninth Circuit Court of Appeals in its recent decision in *Conant v. Walters* (2002) 309 F.3d 629, 647: "[D]octors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending medical marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine."

B. Initial Concerns of the MBC Enforcement Monitor

1. CCU's average complaint processing time is longer than historically reported.

For a number of years, MBC has been counting as "complaints" several categories of information that should not be counted as complaints. As a result, CCU's reported complaint total is artificially high and its reported average complaint processing time is artificially low.

Notices of Intent and National Practitioner Data Bank Reports. As described above, section 801 requires insurers to report to MBC malpractice payouts on physicians. Additionally, insurers are required to report malpractice payouts to the National Practitioner Data Bank, and they send of copy of their NPDB report to MBC. In its 1993 report on MBC's enforcement program, the CHP found that 120 section 801 reports and 2,000 NPDB reports ("some involving settlements in excess of $1,000,000") were sitting unprocessed in the Central Complaint Unit. From then on, CCU began to process — and count as a complaint — every complaint and report it received. When 1993's SB 916 (Presley) enacted Code of Civil Procedure section 364.1 (requiring civil malpractice plaintiffs to send a copy of their "90-day notice of intent to sue letter" to the Medical Board at the same time they send it to the prospective defendant physician), CCU — having just been criticized by the CHP — immediately began to process them and count them as complaints. As to NPDB reports and section 364.1 "notices of intent" (NOIs), CCU would initiate a complaint (to enter it into the system) but close that complaint on the same day.

As the years have passed, the number of NOIs and NPDB reports have increased. As reflected in Exhibit V-C, CCU has annually received between 2,200–2,500 NOIs and 300–400 NPDB reports in recent years — about one-quarter of CCU's reported complaint total. However, these notices have limited significance and should not be grouped with true complaints for statistical purposes. By themselves, NOIs and NPDB reports provide little relevant information to MBC. NOIs are merely a warning that a plaintiff might sue a physician for medical malpractice 90 days hence, and frequently provide little substantive information about the malpractice to be alleged. NPDB reports do not even identify the patient. Further, they are duplicative of other complaints and reports received by CCU. For example, when a patient sues a physician for medical malpractice, it is conceivable that MBC will receive (1) the NOI, (2) a complaint from the patient, (3) a report from the physician's insurer about a judgment or settlement in the matter, and (4) a copy of that same insurer's report to the NPDB. All of these duplicative complaints and reports about the same matter have been counted as separate complaints since 1993, and have skewed CCU's complaint total upward.

Further, because NOIs and NPDB reports are so different in character from other complaints, and because complaints based on NOIs and NPDB reports are opened and closed on the same day,

inclusion of these two notices as "complaints" skews CCU's overall complaint processing time downward and presents a potentially misleading picture. For example, in its 2002–03 annual report, MBC reported that CCU received a total of 11,556 complaints and took an average of 53 days to process complaints. However, 2,661 of the reported 11,556 complaints (23%) were NOIs and NPDB reports opened and closed on the same day[118] — and excluding them yields a more accurate average CCU complaint processing time of 64 days (not 53 days, as reported).

The Monitor has recommended that CCU discontinue counting NOIs and NPDB reports as "complaints." CCU and enforcement management agreed with the Monitor's suggestion, and both NOIs and NPDBs have been excluded from the "complaints received" total reported in MBC's 2003–04 annual report.

Change of Address Citations. The inclusion of another category of case as both a "complaint" and an "investigation" is further skewing downward the average case cycle times in both CCU and investigations. Known as "change of address citations," these occur when MBC's Licensing Unit mails a physician licensee his/her license renewal notice and it is returned to the Board because the address is incorrect — the physician has moved but has failed to notify MBC in a timely manner as required by law. When this occurs (and it occurs 300–340 times per year), a complaint is initiated by CCU and it is immediately (on the same day) referred to the Board's Citation and Fine Unit for the issuance of a citation. For some reason, these are counted both as "complaints" and "investigations," although neither CCU nor investigations has handled the matter. As reflected in Exhibit VI-G below, the exclusion of "change of address citations" from CCU's average 2002–03 complaint processing time yields an average 67-day timeframe (as opposed to the 53 days reported in MBC's 2002–03 annual report and the 64-day average when NOIs and NPDBs are excluded — see above).

Ex. VI-G. FY 2002–03 CCU Physician Complaint Processing Timeframes By Disposition and Day Range

Day Range	Closed By CCU[1]		Referred to Investigation[2]		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	2,272	37.3%	1,025	57.3%	3,297	41.9%
1 to 2 Months	955	15.7%	193	10.8%	1,148	14.6%
2 to 3 Months	918	15.1%	159	8.9%	1,077	13.7%
3 to 4 Months	715	11.7%	144	8.0%	859	10.9%
4 to 6 Months	802	13.2%	162	9.1%	964	12.2%
More than 6 Months	427	7.0%	106	5.9%	533	6.8%
Total, Excluding Change of Address Citations	**6,089**	**100.0%**	**1,789**	**100.0%**	**7,878**	**100.0%**
Average Timeframe, Excluding Change of Address Citations	**71 Days**		**52 Days**		**67 Days**	
Change of Address Citations (1-Day Processing Timeframe)	0	0.0%	340	16.0%	340	4.1%
Total, Including Change of Address Citations	**6,089**	**100.0%**	**2,129**	**100.0%**	**8,218**	**100.0%**
Average Timeframe, Including Change of Address Citations	**71 Days**		**44 Days**		**64 Days**	

[1] Excludes NOI and NPDB Reports. Includes 12 complaints that took longer than a full year.

[2] Includes 3 complaints that took longer than a full year.

Source: Medical Board of California

[118] *See supra* Ex. V-C.

As noted above, MBC has agreed not to count NOIs and NPDB reports as "complaints" in its 2003–04 annual report, and — partly as a result of their exclusion — average CCU complaint processing time jumped from a reported 53 days in 2002–03 to 76 days in 2003–04.[119] However, and as reflected in Exhibit VI-H below, the exclusion of 327 "change of address citations" reflects an actual 79-day CCU average complaint processing time.

Ex. VI-H. FY 2003–04 CCU Physician Complaint Processing Timeframes By Disposition and Day Range

Day Range	Closed By CCU[1]		Referred to Investigation[2]		Total	
	Number	Percent	Number	Percent	Number	Percent
1 Month or Less	2,446	35.7%	835	53.4%	3,281	39.0%
1 to 2 Months	1,034	15.1%	155	9.9%	1,189	14.1%
2 to 3 Months	919	13.4%	140	9.0%	1,059	12.6%
3 to 4 Months	724	10.6%	122	7.8%	846	10.1%
4 to 6 Months	918	13.4%	144	9.2%	1,062	12.6%
More than 6 Months	803	11.7%	167	10.7%	970	11.5%
Total, Excluding Change of Address Citations	**6,844**	**100.0%**	**1,563**	**100.0%**	**8,407**	**100.0%**
Average Timeframe, Excluding Change of Address Citations	**82 Days**		**66 Days**		**79 Days**	
Change of Address Citations (1-Day Processing Timeframe)	0	0.0%	327	17.3%	327	3.7%
Total, Including Change of Address Citations	**6,844**	**100.0%**	**1,890**	**100.0%**	**8,734**	**100.0%**
Average Timeframe, Including Change of Address Citations	**82 Days**		**54 Days**		**76 Days**	

[1] Excludes NOI and NPDB reports. Includes 64 complaints that took longer than a full year.

[2] Includes 14 complaints that took longer than a full year.

Source: Medical Board of California

Chapter VII below describes the much greater impact on average investigative case cycle time of excluding change of address citations.[120]

The Monitor does not believe that CCU intends to mislead in any way with regard to its total number of complaints or its complaint processing timeframes. As described above, CCU started counting NOIs and NPDBs as complaints in response to criticism by the CHP in 1993. And it is unclear why "change of address citations" have been counted as both citations *and* complaints; CCU management believes the outdated CAS system may require MBC to count "change of address citations" as complaints and investigations in order to process them.

In any event, the purpose of such statistical tools in a management information system is to assist in the accurate tracking and evaluation of work done. This purpose can only be served when categories of work outputs are logical and consistent, and when those categories do not group together tasks which are inherently different and non-comparable. It does not help the management

[119] Another factor leading to the increase in CCU average case processing time from 53 days in 2002–03 to a reported 76 days in 2003–04 is the delay caused by the specialty reviewer requirement in Business and Professions Code section 2222.08, which is discussed below.

[120] *See infra* Ex. VII-A.

process to group tasks requiring little or no true complaint-handling work — essentially bookkeeping notations — together with tasks requiring substantive work. MBC can and should maintain records of these one-day recordkeeping tasks, but they should be maintained separately from the substantive complaints and citations.

2. CCU complaint processing takes too long.

Business and Professions Code section 2319(a) requires MBC to establish a goal "that an average of no more than six months will elapse from the receipt of a complaint to the completion of an investigation." For cases involving "complex medical or fraud issues or complex business or financial arrangements," section 2319(b) permits an average of one year from receipt of the complaint to conclusion of the investigation. These "goal" timeframes include the time it takes CCU to process and screen complaints.

As described in Chapter VII, MBC's average investigative time by itself exceeds the 180-goal established in section 2319. CCU's average case processing time must be added to that in computing MBC's compliance with the section 2319 goal.

For fiscal year 2002–03, MBC reported 53 days as CCU's average complaint processing time. As reflected in Exhibit VI-G above, however, it actually took CCU an average of 67 days — or 2.23 months — to process all complaints during 2002–03 (excluding one-day NOIs, NPDB reports, and "change of address citations").

For fiscal year 2003–04, MBC has excluded all NOI and NPDB report processing from its average complaint processing timeframe, and reports an average 76-day complaint processing timeframe. When excluding "change of address citations" from the calculation, CCU's average rises to 79 days (2.63 months) — 12 days longer than it took CCU to process complaints in 2002–03.

It is instructive to look at the difference between average case processing times for QC complaints as opposed to PC complaints. As described above, QC complaint processing generally involves (1) a CCU request for the patient's signature on a release; (2) a CCU request for the patient's medical records; and (3) review of those medical records and other materials submitted by the subject physician by a "specialty reviewer" under section 2220.08. In 2003–04, the average time from receipt of a QC complaint to completion of the medical consultant's review was 140 days (4.66 months, which by itself almost exhausts the 180-day goal in section 2319). Approximately ten of these days are consumed by complaint receipt and initiation. During the remaining 130 days, the CCU analyst requests and waits for medical records, CCU locates a "specialty reviewer" medical consultant, and the consultant reviews the matter and writes an opinion.

CCU estimates that, on average, medical records procurement during 2003–04 took 66 days, and medical consultant review took another 64 days. The time consumed by the "specialty reviewer" requirement is discussed in more detail below. However, the time consumed by CCU in procuring medical records deserves mention here. Business and Professions Code section 2225(d) requires physicians to produce medical records within 15 days of request by the Medical Board, "unless the licensee is unable to provide the documents within this time period for good cause. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct." Average medical records procurement time in CCU takes over four times the statutory 15-day period. CCU's procedure involves an initial request followed by a waiting period of three weeks. If no records arrive, CCU sends a second letter which mentions the possibility of $1,000-per-day fines authorized in section 2225.5. If there is still no response after two weeks, either a third letter is mailed or (since mid-2004) CCU asks its assigned DAG to telephone the physician and urge compliance with the request. This lengthy process results in an average 66-day CCU turnaround time between request for and receipt of medical records, and is exacerbated by the *additional* 74-day average spent by field offices on medical records procurement.[121] Combined, MBC spends an average of 140 days — or 77% of the 180-day "goal" established in section 2319 — on medical records procurement alone.

As discussed in Chapters VII and IX, the medical records procurement issue is a serious problem at MBC and HQE. The Monitor believes that CCU, MBC field investigators, and HQE attorneys are handicapped by a "culture" of routine toleration of lengthy delays by physicians and health care institutions in responding to lawful MBC requests for medical records. This tolerance of delay is occurring within the context of quality of care cases — the focus of SB 1950 (Figueroa). The medical records procurement issue must become the target of a focused effort by both MBC and HQE. Lengthy delays should no longer be tolerated, and MBC should use the tools available to it (including warrantless searches where MBC has a patient release, an administrative inspection warrant under Code of Civil Procedure section 1822.5, prompt issuance of subpoenas under Government Code section 11180 *et seq*., immediate subpoena enforcement in the event of noncompliance, and requests for the fines available in section 2225.5) to force compliance with the medical records laws.[122]

3. CCU's implementation of the specialty reviewer requirement for QC complaints has caused a number of problems.

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[121] *See infra* Ch. VII.B.

[122] This is not a new problem, and the Monitor is not the first to recommend this solution. In an October 7, 2002 memo to the members of the Board's Enforcement Committee, Committee Chair Ron Wender, MD, suggested adoption of a "zero tolerance policy regarding obtaining records. Business and Professions Code section 2225 with the imposition of a $1,000/day civil penalty will be utilized for lack of compliance."

As described above, SB 1950 (Figueroa) added section 2220.08, which requires CCU — before referring most QC complaints to the field for investigation — to ensure they have been "reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required."[123]

This specialty reviewer requirement has been implemented rather strictly by CCU,[124] and the method of implementation has caused substantial delay in the processing of quality of care cases in certain specialties (including neurology, radiology, and cardiology). A major goal of SB 1950 was to expedite the processing of QC cases, especially QC cases in the section 2220.05 priority categories, and the specialty reviewer requirement has not yet served that goal.

We compiled data on all reviews completed by CCU medical consultants during calendar year 2003. We also analyzed the total number of reviews that were pending as of December 31, 2003. The term "pending cases" includes two categories: (1) those that had been assigned to an identified reviewer as of December 31, 2003, and (2) those that were unassigned as of December 31, 2003 and were sitting on a shelf in the Central Complaint Unit. We also separated our analysis into two categories: (1) "high-volume specialties" — those specialties that are often the subject of complaints and in which CCU has a number of trained and experienced reviewers, and (2) "low-volume specialties" — specialties and subspecialties in which relatively few physicians practice and/or are less often the subject of complaints, and in which CCU has no (or very few) trained and experienced reviewers. Exhibits VI-I and VI-J below are the products of our analysis.

[123] None of the legislative analyses of SB 1950 discuss this provision in detail. However, its genesis may be attributed to the following statement in the Joint Legislative Sunset Review Committee's May 1, 2002 background paper on MBC's 2001–02 sunset review: "There appears to be no formal requirement that a Medical Consultant evaluating a complaint *must* consult with a physician expert in the relevant sub-specialty before the Consultant can recommend that the case be closed, either with or without merit. Whether a Medical Consultant who is, say, a pediatrician, should be permitted to render an opinion on, say, an oncology case, is left to the Consultant's discretion." The background paper also noted that 24 specialties are currently recognized by the American Board of Medical Specialties, but the CCU medical consultants used in the prior year represented only ten of those specialties.

[124] Several defense attorneys complained that CCU is shipping some complaints to the field without affording their clients the "right" to a specialty review under section 2220.08. However, CCU's procedure manual is quite clear that all quality of care complaints must undergo specialty review. Some complaints properly go to the field without specialty review. By implication, non-quality of care complaints need not undergo specialty review. Also, the statute excepts some cases from the specialty reviewer requirement — including section 805 cases and matters in which MBC intends to seek interim relief.

Ex. VI-I. CY 2003 CCU Medical Consultant Reviews of QC Cases: High-Volume Specialties

Specialty	Completed Reviews (CY2003)				Total Pending Reviews		Unassigned		Assigned			
	Number	Days Unassigned	Days Assigned	Total Days	Number	Total Days	Number	Total Days	Number	Days Unassigned	Days Assigned	Total Days
Internal/General Medicine	795	12	21	33	106	35	70	27	36	21	30	51
Obstetrics & Gynecology	177	16	28	44	36	38	25	24	11	40	31	71
Pediatrics	67	15	23	38	7	67	4	18	3	83	49	132
Psychiatry	84	10	20	30	6	32	5	15	1	21	92	113
Surgery	147	25	16	40	12	71	6	49	6	47	46	93
High-Volume	**1,270**	**14**	**21**	**35**	**167**	**39**	**110**	**27**	**57**	**31**	**34**	**65**

Source: Medical Board of California

Ex. VI-J. CY 2003 CCU Medical Consultant Reviews of QC Cases: Low-Volume Specialties

Specialty	Completed Reviews (CY2003)				Total Pending Reviews		Unassigned		Assigned			
	Number	Days Unassigned	Days Assigned	Total Days	Number	Total Days	Number	Total Days	Number	Days Unassigned	Days Assigned	Total Days
Anesthesiology	28	32	39	71	22	55	13	24	9	58	42	100
Cardiology	52	60	28	88	8	56	5	36	3	39	50	89
Dermatology	18	71	20	91	13	51	12	43	1	73	67	140
Emergency Medicine	3	19	14	33	9	30	6	22	3	14	33	47
Endrocrinology	2	87	30	117	0	0	0	0	0	0	0	0
Gastroenterology	21	22	31	53	4	37	1	15	3	19	25	44
Hematology/Oncology	10	52	22	74	10	37	10	37	0	0	0	0
Neonatal/Perinatal	3	82	38	120	1	7	1	7	0	0	0	0
Nephrology	3	0	31	31	0	0	0	0	0	0	0	0
Neurological Surgery	10	23	14	37	5	109	4	97	1	118	36	154
Neurology	3	61	22	83	16	90	6	46	10	72	45	117
Ophthalmology	54	27	23	50	12	44	10	32	2	36	68	104
Orthopaedic Surgery	43	58	27	85	28	68	24	55	4	80	66	146
Orthopaedics	48	43	21	64	7	36	6	35	1	6	36	42
Otolaryngology	25	49	16	65	3	84	1	50	2	38	64	102
Pathology	2	80	14	94	0	0	0	0	0	0	0	0
Pain Medicine	7	55	8	63	3	64	0	0	3	23	41	64
Physical Medicine & Rehabilitation	11	111	15	126	1	1	1	1	0	0	0	0
Reconstructive Surgery	52	30	20	50	37	78	14	34	23	26	79	105
Pulmonology	8	24	30	54	1	42	1	42	0	0	0	0
Radiology	54	41	26	67	20	56	16	36	4	83	52	135
Rheumatology	2	43	28	51	1	26	1	26	0	0	0	0
Spine Surgery	2	58	58	116	10	110	6	75	4	92	71	163
Urology	25	68	21	89	7	37	3	14	4	40	13	53
Low-Volume	486	45	24	69	218	63	141	40	77	47	56	103

Source: Medical Board of California

As for the high-volume specialties, CCU medical consultants completed 1,270 reviews within an average of 35 days during calendar year 2003. As of December 31, 2003, 167 cases were pending: 110 had not yet been assigned to a reviewer, and 57 were assigned to and pending with an identified reviewer as of December 31, 2003. Combined, the "pending" cases had been pending for an average of 39 days. As for the low-volume specialties, CCU medical consultants completed 486 reviews within an average of 69 days during calendar year 2003 — nearly twice as long on average as compared with completed high-volume specialty reviews. As of December 31, 2003, 218 cases were pending. Only 77 of those cases had been assigned to an identified reviewer, and they had already been with that reviewer for an average of 103 days — suggesting that physicians in these high-demand specialties do not give high priority to reviewing MBC cases at $75 per hour. The remaining 141 cases were literally sitting on a shelf in CCU, and had been there for an average of 40 days. Many investigators we interviewed agreed with the sentiment expressed by one of their colleagues: "One reason our caseloads are so low is that cases are clogged in CCU waiting for specialty review — and they're trickling down here a little older. I got one case that's already close to the statute of limitations."

Delay in the processing of QC cases is not the only result of CCU's implementation of the specialty reviewer requirement. CCU has had to devote significant time (the total of about two personnel-years) to recruiting and training new specialty reviewers, limiting the amount of time these employees can spend on their other assigned duties. In addition, because CCU has been unable to locate qualified reviewers on its own, it has "borrowed" expert witnesses from the list of experts used by the district offices (discussed in Chapter VIII below). These experts must be paid more than CCU medical consultants ($100 per hour for expert reviewers vs. $75 per hour for CCU medical consultants), they are accustomed to performing a full and in-depth review for district offices (which is often unnecessary at the CCU level) and thus use more hours than do experienced CCU reviewers, and their use strips the district offices and HQE prosecutors of the ability to use them in the same case — lessening the overall number of medical experts available to MBC in quality of care cases.

Further, there is no consensus that the quality of reviews or fairness to physicians has improved due to the use of specialty reviewers. Certainly the quantity of reviews completed has not improved. Exhibit VI-K below reviews CCU dispositions following a medical consultant review for calendar years 2000, 2001, and 2002 (before the specialty reviewer requirement was enacted), and 2003 (when it became effective). The exhibit indicates that fewer medical consultant reviews are being completed now (2,383 in CY 2003, as compared with 2,995 in 2000, 2,972 in 2001, and 3,065 in 2002), and of those being completed, the same percentage is being closed (approximately 80%) vs. referred for investigation (approximately 20%). And as for quality, we interviewed investigators, medical consultants in district offices, and prosecutors who read and rely on CCU expert reviews every day. Few have noticed an appreciable increase in the quality of reviews performed since January 1, 2003; most indicated that any heightened quality is not worth the delay

and cost inherent in locating members of very highly-paid specialties to review boxes of records at $100 per hour.

Ex. VI-K. CCU Disposition of Physician Complaints Following Medical Consultant Review

Disposition	CY 2000		CY 2001		CY 2002		3-Year Average		CY 2003	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Closed (no violation)	1,995	66.6%	1,667	56.1%	1,893	61.8%	1,852	61.5%	1,460	61.3%
Closed (insufficient evidence)	369	12.3%	581	19.5%	507	16.5%	486	16.1%	354	14.9%
Closed (info on file)	30	1.0%	65	2.2%	52	1.7%	49	1.6%	61	2.6%
Closed - Other	23	0.8%	41	1.4%	22	0.7%	29	1.0%	30	1.3%
Subtotal	2,417	80.7%	2,354	79.2%	2,474	80.7%	2,415	80.2%	1,905	79.9%
Referred to INV	578	19.3%	618	20.8%	591	19.3%	596	19.8%	478	20.1%
Total	2,995	100.0%	2,972	100.0%	3,065	100.0%	3,011	100.0%	2,383	100.0%

Source: Medical Board of California

Few would disagree with the concept of improving quality by bringing greater expertise to bear, where feasible. The challenge in this connection is how to advance SB 1950's sound goal in a manner which does not unduly encroach on SB 1950's equally important goal of improved case cycle times.

The Monitor believes that MBC may be interpreting the statute too narrowly. The American Board of Medical Specialties recognizes 24 specialties; yet CCU utilized physicians in 29 specialties to review QC cases in 2003. The statute does not require review by someone in an identical specialty or subspecialty, or even someone in the "same or similar" specialty or subspecialty. The statute requires a review by a physician "with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required." Not every complaint against a subspecialist pertains to the subspecialty; some complaints go to (in the words of an experienced CCU medical consultant we interviewed) "the basic, core skills of a physician. Did you get informed consent? Did your treatment follow and support your diagnosis?" In those types of cases, it would appear that generalists would be able to review medical records competently for purposes of recommending whether the case should be referred for formal investigation and full review by a medical expert in the specialty. The Monitor recommends that MBC revisit its CCU expert reviewer policy with an eye toward refining its requirements and lowering the average amount of time it takes for review of "low-volume" specialties.

In addition, consideration should be given to amending section 2220.08 to provide an exception to the "specialty reviewer" requirement where CCU is unable to locate a specialist after a 30-day good-faith search. Review at the CCU level is not supposed to be a full-scale expert opinion; it is merely a review to determine whether the complaint should be referred for investigation — where it will be reviewed in detail by a specialist. The goal of SB 1950 (Figueroa) is expedited handling of quality of care cases in which patients have been harmed — and allowing such cases to

languish for 35–70 days while CCU searches for a specialist reviewer when one may not be needed is inconsistent with that goal.

4. The codification of mandatory case processing priorities is resulting in unintended consequences.

SB 1950 (Figueroa) added section 2220.05, which requires MBC to "prioritize its investigative and prosecutorial resources to ensure that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously." No one quarrels with this sound goal. The addition of section 2220.05 was apparently borne of dissatisfaction with MBC's pre-existing priority system.[125] However, the codification of mandatory case processing priorities — or perhaps MBC's good-faith implementation of that mandate — has caused unintended consequences that warrant exploration.

It is important to begin with what the statute actually says and what it does not say. Section 2220.05 says that complaints falling into one of five stated categories — which attempt to capture physicians "representing the greatest threat of harm" — should be "identified and disciplined expeditiously." It says that in its annual report of its enforcement output to the Legislature, MBC must indicate the number of temporary restraining orders, interim suspension orders, and disciplinary actions taken in each of the five categories. The statute does not say that MBC may investigate, prosecute, and take disciplinary action only in cases falling into one of the five priority categories. And it does not say that MBC may not investigate, prosecute, and take disciplinary action in cases falling outside the five categories. Nonetheless, defense counsel are interpreting it that way in sometimes misleading fashion. The Monitor has observed defense counsel arguing that discipline should not be imposed in a given case — including cases investigated and filed long before section 2220.05 became effective — because it does not fit within the section 2220.05 priorities.[126]

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[125] The Joint Legislative Sunset Review Committee's May 1, 2002 background document for MBC's 2001–02 sunset review states: "Board Complaint and Investigative Priorities are Questionable. 'Urgent' complaints receive the highest Board investigative priority, but what is classified as 'urgent' is open to question. The Board's *Policy and Procedure – Complaint Handling Priorities* states that 'High priority complaints are to be processed expeditiously as next in order following urgent complaints.' 'Quality of care – Patient Death' and 'Quality of Care – Gross Negligence/ Incompetence' cases are classified as 'high priority,' not 'urgent.' In contrast, sexual misconduct allegations or a doctor's self-abuse of drugs or alcohol are considered 'urgent.'"

[126] *See, e.g.*, Answer to Petition for Review filed in the California Supreme Court by David Louis Bearman in *Bearman v. Superior Court (Joseph, Real Party in Interest)*, No. S124693 (petition for review denied June 30, 2004). In this subpoena enforcement action stemming from a complaint received by MBC in April 2001 (one and one-half years before section 2220.05 became effective), defense counsel argued to the California Supreme Court in May 2004 that it should not review the court of appeal's decision invalidating a Medical Board subpoena because the subject matter of the relevant complaint "does not even appear on the [section 2220.05] list."

Further, both the language of the statute and the way in which MBC has implemented the section 2220.05 priorities have elevated *patient outcome* over factors which may be as or more important in enforcement circumstances, including imminence of harm, strength of evidence, and culpability. Patient injury or death is always tragic. Sometimes it is the fault of the doctor; many times it is not. But the mere presence of a tragic outcome should not necessarily dictate prioritization of enforcement activity. MBC's goal should be to best protect the public; maximizing public protection often means considering all relevant law enforcement factors, of which patient harm is only the most serious. However, and as reflected in Exhibit VI-C above, one net effect of the statute has been the elevation of all cases where there has been a death or "serious bodily injury"[127] to a patient to U1 status ("gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public"). Exhibit VI-C reveals that over one-fourth of the complaints received during 2003–04 were assigned a U1–U5 priority, and that 85% of those were assigned a U1 priority. Thus, most section 2220.05 priority cases are U1; there were no U2s in 2003–04 (because the U2 category is subsumed by U1), and relatively few U3s, U4s, and U5s. Exhibit VI-L below, which breaks out all complaints pending in CCU as of June 30, 2004, illustrates the concentration of U1 cases.

Not everything can be assigned a U1 priority. If everything is a U1 priority, in effect we have no priority system. But almost every priority case is classified as a U1 priority in the present system.

Ex. VI-L. Pending Complaints as of June 30, 2004

Quality of Care Complaints

Total Pending Complaints	Pending at MC/Specialist	Priority	
1,022	511	U1 (Patient Death/Injury)	358
		U2 (Substance Abuse)	0
		U3 (Excess Prescribing)	13
		U4 (Sexual Misconduct)	0
		U5 (Practice-Drugs/Alcohol)	0
		Non-Priority	140

Non-Quality of Care Complaints

Total Pending Complaints	Pending at MC/Specialist	Priority	
557	0	U1 (Patient Death/Injury)	0
		U2 (Substance Abuse)	0
		U3 (Excess Prescribing)	0
		U4 (Sexual Misconduct)	0
		U5 (Practice-Drugs/Alcohol)	0
		Non-Priority	0

Source: Medical Board of California

[127] The term "serious bodily injury" is not defined in section 2220.05 or any other California statute; thus, CCU's classification of complaints involving injury is necessarily subjective. In an attempt to comply with the intent of the statute, CCU assigns a U1 priority to almost every complaint or report involving injury to a patient.

Further, Exhibit VI-C tells us that 989 of the 2,007 complaints classified as U1 (49%) are section 801/801.1/802/803.2 reports of civil malpractice settlements. Civil settlements often occur several years after the event that prompted the lawsuit. In cases where three or four years have elapsed since the event and the physician has not been the subject of any subsequent complaint or report, it is inappropriate to classify the complaints as U1 because the physician is simply not "a danger to the public" as required in section 2220.05(a)(1). However, that is a judgment call, and MBC has chosen to err on the side of caution and demonstrate absolute compliance with the letter and spirit of the statute.

Conversely, other kinds of complaints posing serious risk of real-time harm and accompanied by strong evidence are relegated to lower status or not included at all on the priorities list. A good argument can be made that it is more important for MBC to move now on a complaint of recent egregious sexual misconduct (U4) or practicing while impaired (U5) than a section 801 report of a civil settlement involving the death of a patient five years ago (U1). A good argument can likewise be made that a felony conviction, aiding and abetting unlicensed practice in backroom clinics, and even some probation violations deserve more expedited treatment than a stale 801 report of a civil settlement stemming from a death five years ago.

Adequate protection of the California public also requires an enforcement presence in other important areas of medical misconduct. No one disputes that a death is a greater tragedy than economic harm or non-fatal unlicensed practice, but a system which inhibits MBC from bringing at least some actions to stop economic harm or unlicensed conduct sends a dangerous signal that such misconduct is tolerated in California. Today, fraud (including egregious insurance fraud that does critical systemic damage to our health care system) and deceptive business practices which injure honest practitioners and consumer victims are relegated to a very low priority by MBC in its current interpretation of its mandate.

A system can be devised to ensure that serious harm or death is given all appropriate priority, while still permitting judicious use of resources to maintain a vital law enforcement presence in other areas of importance. While still giving serious health harm its due significance, MBC should permit its supervisors to identify non-fatal or grievous injury cases where the immediacy of the threat, the strength of the evidence, the need for enforcement deterrence, and the prospects for effective action call for MBC to act. MBC can still make a patient death a high priority, while stopping the drug-addicted surgeon from walking into the operating room tomorrow morning.

All of this suggests that the intent behind section 2220.05 was undeniably good, but putting that intent into words and action is exceedingly complex. The Monitor believes the priorities statute should be refined to effectuate the intent of SB 1950 (Figueroa) and the overall public protection

mandate of the Board — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

5. Many of MBC's most important detection mechanisms are failing it.

Business and Professions Code section 800 *et seq*. sets forth an extensive "mandatory reporting scheme" intended to enable MBC to detect physician negligence, incompetence, dishonesty, and impairment so that it might investigate and take disciplinary action if appropriate. As described in Chapter IV, several of these statutes were enacted in AB 1 (Keene) in 1975, and were further refined to close loopholes in SB 2375 (Presley) (1990), SB 916 (Presley) (1993), and SB 1950 (Figueroa) (2002) — indicating strong legislative intent that MBC be notified of these events so that its discretion to investigate and its public protection mandate might be preserved. As reflected in Exhibits VI-B and VI-F above, section 800 reports are valuable sources of information to the Board leading to investigation, prosecution, and disciplinary action — including disciplinary action taken in section 2220.05 priority cases. However, many of these mechanisms are failing the Board and the public.

■ ***Malpractice Payouts***. Sections 801 and 801.1 require insurance companies and employers of physicians that self-insure to report to MBC specified judgments, settlements, and arbitration awards against physicians within 30 days of the event. Under section 804(b), the reports must be "complete" in that they must include eight specified items of information; section 804(d) further provides that insurers and self-insured employers of physicians that have received "a copy of any written medical or hospital records prepared by the treating physician or the staff of the treating physician or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the claim prompting the Section 801 or 801.1 report, or a copy of any depositions in the matter that discuss the care, treatment or medical condition of the person shall provide with the report copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California to the insurer . . . ." Section 804(d) further requires insurers and self-insured governmental agencies to "maintain the records and depositions referred to in this subdivision for at least one year from the date of the Section 801 or 801.1 report."

The Monitor has looked at a number of section 801 and 801.1 reports (although no provision could be made for a true statistical sampling). Hardly any of them were filed within the required 30-day time period, and most of them were incomplete to the point of being almost useless to the Board (for example, most failed to include the address or contact information of the plaintiff in the malpractice action). During our interviews of dozens of MBC and HQE staff, we were consistently told that the materials required to be forwarded to MBC by section 804 are not forwarded; in fact, on many occasions, they are destroyed as soon as the settlement is reached, making it difficult if not impossible for MBC to proceed in such a matter.

Unlike section 805 applicable to hospitals, sections 801 and 801.1 contain no penalty for failure to file the required report, failure to file a complete report, and/or failure to produce the records that are required to be produced and kept for one year from the date of the report. During its 2001–02 sunset review of MBC, the JLSRC agreed that these laws should provide "penalties against medical malpractice insurers that fail to report malpractice settlements, judgments, and awards to the Board to match those placed on hospitals that fail to file an 805 Report — up to a $50,000 fine for a negligent failure to file, and up to $100,000 for a willful failure to file."[128] The Monitor agrees.

■ ***Coroner's Reports***. Section 802.5 requires a coroner to file a report with MBC whenever the coroner performs an autopsy or otherwise "receives information" from a board-certified pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. As reflected in Exhibit V-C, MBC receives very few coroner's reports — never more than 40 in a given year.

■ ***Physician Self-Reporting of Criminal Convictions***. Section 802.1 limits physician self-reporting of criminal convictions to felonies. It is unclear why misdemeanor criminal convictions are not also required to be reported. Many misdemeanor convictions are the result of a felony charge which is pled down to a misdemeanor; others are the result of a "wobbler" charge (a crime that may be charged either as a felony or a misdemeanor in the discretion of the prosecutor) that is pled down to a misdemeanor. Many misdemeanor criminal convictions are "substantially related to the qualifications, functions, or duties" of a physician and are grounds for disciplinary action.[129] Court clerks are required to report them to MBC;[130] physicians should self-report them as well.

■ ***Court Clerk Reporting***. Similarly, section 803(a)(2) requires court clerks to report specified criminal convictions and civil malpractice judgments in any amount entered against physicians to MBC; section 803.5(a) requires prosecutors and court clerks to notify MBC of felony criminal filings against physicians "immediately upon obtaining information that the defendant is a licensee of the board;" and section 803.5(b) requires the clerk of the court in which a physician is convicted of a felony to "within 48 hours after the conviction, transmit a certified copy of the record of conviction" to MBC. In 2003–04, MBC received three reports from court clerks under section 803(a)(2), and 33 reports of criminal charges and convictions from court clerks and physicians. The

[128] In his October 7, 2002 memo to the Enforcement Committee (*see supra* note 122), Dr. Wender agreed: "[MBC should] institute a system to closely monitor insurance company and hospital compliance with lawful medical records requests; . . . [and] require insurance companies to provide an accurate synopsis of malpractice awards, judgments, and settlements exceeding $30,000 to include the depositions of the defendant, plaintiff, and defendant experts as well as pertinent exhibits."

[129] Bus. & Prof. Code §§ 490, 2236.

[130] *Id.* at § 2236(c).

Board's Public Education Committee has investigated the low level of compliance with these statutes by court clerks. They generally do not comply because (1) they do not know the reporting requirements exist, and (2) even if they know of the reporting requirement, they may not know the defendant is a physician.[131]

■ ***Hospital Reporting of Adverse Peer Review Action***. Section 805 reporting by hospitals, health care facilities, and HMOs is one of the most valuable source of complaints resulting in investigation, prosecution, and disciplinary action, and is the greatest area of failure. According to the Office of Statewide Health Planning and Development, there are 521 hospitals in California; additionally, there are numerous other health care facilities and managed care organizations that are subject to the reporting requirements of section 805. In 2003–04, MBC received only 157 section 805 reports. This is actually a high number compared with 124 filed in 1993–94[132] and the record low of 82 in 1998–99.

In *Arnett v. Dal Cielo*,[133] a hospital challenged MBC's authority to subpoena peer review records, arguing that the Board is not entitled to them under Evidence Code section 1157 and that forcing hospitals to turn peer review records over to MBC would stifle physicians' willingness to serve on peer review committees, thus "chilling" the entire process. In a unanimous decision, the California Supreme Court upheld the Board's authority to subpoena peer review records on physicians under investigation by MBC, and articulated the importance of the conduct of peer review at hospitals and the reporting of adverse peer review actions to the Medical Board of California — whose duty to protect "all consumers of medical services in California" outweighs a hospital's interest in protecting only its own patients, and whose "paramount public protection priority" similarly trumps a hospital's "private purpose of reducing the exposure of the hospital to potential tort liability." In other words, the Court demanded compliance with section 805 because one of the purposes behind private peer review is to support MBC's enforcement program — not the other way around.

Since the *Dal Cielo* decision, a number of events have occurred that have affected compliance with section 805. First, 1998's AB 103 (Figueroa) — for the first time — authorized MBC to publicly disclose some peer review decisions: those that result in "termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason."

Next, after the record low 82 section 805 reports in 1998–99, the Senate Business and Professions Committee held a public hearing in the fall of 2000 to investigate whether hospitals were

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[131] *See infra* Ch. XIV.A.

[132] When MBC learned of that only 124 section 805 reports had been filed in 1993–94, it published a front-page story in its January 1995 *Action Report* licensee newsletter decrying the apparent noncompliance with section 805 and calling on hospitals to obey the law and help MBC protect the public. *See supra* Ch. IV.D.

[133] 14 Cal. 4th 4 (1996).

in fact failing to comply with the reporting requirement, or not engaging in peer review, or whether they have restructured their peer review processes to avoid the events that trigger the reporting requirement. Numerous witnesses — including MBC — testified that the penalty for failure to report was simply too low to deter noncompliance; several hospitals intentionally failed to report for their own reasons and simply paid the low fine as a cost of doing business. As a result of the public hearing, SB 16 was enacted in 2001.[134] Among other things, SB 16 increased the maximum fine for willful failure to file an 805 report from $10,000 to $100,000, and from $5,000 to $50,000 for other failures to file. The bill also made failure to file an 805 report by a physician reporter unprofessional conduct and grounds for disciplinary action. Importantly, SB 16 also added section 805.2, which states the Legislature's intent "to provide for a comprehensive study of the peer review process as it is conducted by peer review bodies . . . in order to evaluate the continuing validity of Section 805 and Sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California." In his signing message, Governor Davis indicated his expectation that MBC would come up with the $300,000 needed to conduct the study within its existing resources. Because the Legislature has not increased MBC's license fees since 1994 and due in part to the 2001 budget cuts, that study has never been funded and never been conducted.

Although the number of section 805 reports is up slightly in recent years, the evidence indicates that compliance with section 805 is lower than it appears. The Board received 157 reports in 2003–04, but fully one-third of those were taken by hospitals against a physician's privileges *after* the Medical Board disciplined the physician's license. Thus, rather than peer review assisting MBC in detecting dangerous physicians, the tail is wagging the dog and MBC is prompting hospitals to finally take peer review action against physicians. The case highlighted by the *Orange County Register* in its April 2002 "Doctors Without Discipline" series[135] illustrates hospitals' continuing failure to report adverse peer review action to the Board. Further, the number of disclosable 805 reports has dwindled to almost none; only six (6) disclosable section 805 reports were filed in 2003–04.

■ ***Regulatory Gag Clauses***. In addition to the failure of the affirmative reporting mechanisms described above, CCU is often deprived of information about dangerous physicians through the inclusion of "regulatory gag clauses" in civil settlement agreements. When a patient sues a physician for medical malpractice, the physician may decide to settle with the patient. However, as a condition of settlement, the physician demands that the consumer agree not to contact the Medical Board, not to cooperate with the Medical Board (should the Board contact the patient upon receiving the section 801 report of the settlement), and/or to withdraw a complaint pending before the Board. The impact of these clauses is momentous for MBC — consumers who have just been involved in litigation with a physician who has injured them will not readily risk further breach

[134] *See supra* Ch. IV.F.

[135] *See supra* Ch. IV.G.

of contract litigation with that same physician by cooperating with MBC. They will not sign a release authorizing MBC to obtain their records from the physician who injured them. Even if MBC somehow subpoenas those records and files an accusation, the victim will not readily testify at the hearing against that physician.

Regulatory gag clauses cause many serious problems — both for the Medical Board that is being deprived of information about its own licensees by its own licensees and for unsuspecting patients who continue to be exposed to unscrupulous and/or incompetent physicians because MBC cannot take appropriate disciplinary action against them — the very antithesis of the purpose of all regulatory agencies and especially the Medical Board. Regulatory gag clauses also encourage an irresponsible business model that affirmatively injures people: Despite repeated malpractice actions and repeated settlements, physicians are able to gag their victims so they cannot contact or cooperate with MBC, leaving the doctors free to turn right around and do it again — with MBC unable to do anything about it because it doesn't have a cooperative victim.

In support of a 2004 bill to ban the inclusion of regulatory gag clauses in civil settlement agreements,[136] MBC recently documented some of the costs of regulatory gag clauses.[137] The Board described a dozen recent cases from all over the state in which a regulatory gag clause hindered or prevented investigations and/or prosecutions. These cases documented the considerable time CCU must spend attempting to persuade reluctant patients that the use of regulatory gag clauses by physicians has been invalidated by the courts[138] — which court decision seems not to have deterred physicians from inserting gag clauses into settlement agreements. If CCU cannot persuade the patient to sign a release for medical records (which records are otherwise privileged), it can request HQE to subpoena the records and then enforce the subpoena through a motion before the courts. This process takes time — and some cases in which gag clauses were used had to be closed because the accusation could not be filed within the Board's statute of limitations.[139] This process also costs money — in one case arising out of San Jose, the existence of a gag clause in a civil settlement agreement cost MBC an additional 24 months in investigative time and $25,000 in attorneys' fees for the preparation and enforcement of a subpoena.

Regulatory gag clauses should be statutorily banned for all regulated trades and professions and particularly for physicians in light of the irreparable harm they can cause if they are incompetent,

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[136] AB 320 (Correa), vetoed by Governor Schwarzenegger on September 22, 2004.

[137] Medical Board of California, *Investigation of Impact of Regulatory Gag Clauses: Preliminary Findings* (January 13, 2004).

[138] *Mary R. v. Division of Medical Quality of the Board of Medical Quality Assurance* (1983) 149 Cal. App. 3d 308.

[139] Bus. & Prof. Code § 2230.5.

negligent, dishonest, or impaired. No physician should be permitted to deprive MBC of information about misconduct committed by that physician in the course and scope of the practice of medicine regulated by the State of California.

6. The staffing allocations of CCU's sections should be revisited.

The split of CCU into two sections has allowed SSAs to specialize in particular kinds of complaints, which can lead to greater efficiency because of familiarity with the subject matter and the process. However, the Monitor believes that CCU should revisit the allocation of staffing between the quality of care and physician conduct sections. That staffing was based on the pre-2003 assumption that MBC would receive more QC than PC complaints. As illustrated in Exhibits VI-D and VI-E, the reverse is true: MBC receives more PC than QC complaints. As a result of the current staffing allocations, QC analysts — who spend a lot of time waiting for patient releases, medical records, and medical consultant review and could probably handle slightly higher caseloads — have lower caseloads than do PC analysts. While it is true that some PC complaints can be closed very quickly, other kinds of PC complaints are quite complex and are vitally important to public protection.

All CCU analysts carry massive caseloads. As of September 2004, the eight QC analysts carried an average of 68 cases each, while the six PC analysts carried an average of 97 each. Of particular concern, the *one* PC analyst who processes all complaints alleging sexual misconduct and drug/alcohol offenses — both of which are section 2220.05 priority categories — had 94 cases on his desk as of September 16, 2004. If and when he is ill, called for jury duty, goes on vacation, or is out of the office for any reason, those potentially very serious complaints just sit there and accumulate.[140] There is little or no cross-training of SSAs or an assigned back-up in these priority case areas, and insufficient staffing to enable other SSAs to leave their work for his work.

7. Detection of repeated negligent acts has improved, but could be enhanced.

As described above, CCU has responded to the JLSRC staff's 2002 concern that CCU appeared to be closing quality of care cases in which a "simple departure" had been determined without checking whether that physician had been the subject of prior complaints in which other "simple departures" had been found — such that the physician might be prosecuted for "repeated negligent acts" under section 2234(c). CCU's new procedure calls for identification of "simple departure" findings in QC cases by a senior program analyst, and review of that physician's prior complaint history by CCU's senior medical consultant and assigned DAG.

[140] MBC notes that incoming complaints that accumulate on the desk of any absent CCU analyst are examined on a weekly basis.

Thus, CCU has instituted a review process for "simple departures" in the QC area. However, to our knowledge, it has not instituted a similar review for "simple departures" in the PC area — in complaints alleging sexual misconduct, practicing while under the influence of drugs/alcohol, and other important areas. Inasmuch as these two areas are priority categories under section 2220.05, it would seem appropriate to trigger a review of "simple departure" findings in PC cases in order to detect repeat offenders.

8. CCU should ensure that subject physicians are notified when complaints are closed or forwarded for investigation.

MBC policy sets standards for CCU communication with complainants and with subject physicians. As noted above, state law requires MBC to acknowledge the receipt of a complaint to the complainant within ten days. Thereafter, the CCU policy and procedure manual requires CCU to communicate with the complainant if and when: (1) CCU needs a signed release for medical records; (2) the complaint is sent to a medical consultant; (3) the complaint is referred for investigation; and (4) the complaint is closed. CCU also mails various brochures on the enforcement program to complainants at various stages of the process.

When we interviewed members of the defense bar, they expressed concern that CCU does not always notify their clients when a complaint is received, closed, or referred for investigation. As for the subject physician, CCU communicates with that physician if it needs medical records. At that point in the process, CCU sends the physician a letter including "a comprehensive summary of the substance" of the complaint[141] and requesting all relevant medical records. Thereafter, if the

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[141] *See* Bus. & Prof. Code § 800(c). The defense attorneys also complained about MBC's implementation of section 800(c), a provision requiring MBC to maintain a "central file" on each licensee that contains specified information, including complaints. Section 800(c) permits a licensee to "inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source *or by providing a comprehensive summary of the substance of the material*. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, *or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications*" (emphasis added).

In responding to section 800(c) requests by licensees for complaint information, MBC has chosen to prepare "comprehensive summaries" rather than to release the actual complaint with the identity of the complainant redacted. Defense attorneys object to this procedure on several grounds. First, they contend the summaries are not always "comprehensive." They note that if MBC files an accusation, the complaint is discoverable and defense counsel will obtain it anyway. More importantly, defense counsel assert that obtaining a copy of the actual complaint would help their clients respond more promptly to CCU requests for medical records, and would relieve the anxiety that their clients suffer when called in for a "subject interview" with an investigator about a complaint they know little about.

In response, MBC notes that not all complaints are typed neatly on a form where all information about complainant identity (for purposes of redaction) is easily located. Some complaints are lengthy handwritten missives, and it is more time-consuming to MBC staff to find and redact all identifying information (as required by the statute) than

complaint is closed, section 9.2 of CCU's procedure manual requires it to notify the subject of the closure if he or she has been contacted during the review process.[142]

If CCU does not need medical records from the physician (because, for example, it is non-quality of care case that does not require medical records, or it is an 805 report that is referred directly to the field without CCU screening), then — under current policy — it is possible that the physician will not learn of the pendency of the complaint until it has been referred for investigation. Although physicians might wish for such notice as a matter of courtesy, the Monitor is not disturbed by the fact that MBC does not provide that notice. Generally, a prosecutor is under no obligation to inform a subject that a consumer or patient complaint has been filed or that he is under investigation. In fact, imposing a blanket rule that all subjects of complaints be informed of a pending investigation would interfere with potential undercover operations, and might encourage the destruction or alteration of medical records.

If the complaint is referred for investigation and additional medical records and/or a subject interview is needed, the district office investigator will inform the physician of the pendency of the investigation. If the district office thereafter decides to close the case, the Board's Enforcement Operations Manual is somewhat inconsistent on whether the physician must be notified of the closure. On the one hand, the *Manual* states: "It is the Medical Board of California (MBC) Enforcement Program policy to notify the complainant(s) and subject on all case dispositions, not just those cases closed with no violation or insufficient evidence."[143] On the other hand, if the district office decides to close a case, the manual instructs the assigned investigator to notify the physician only if he/she was contacted by that investigator during the course of the investigation.[144] Similarly, the *Manual* is unclear whether the subject will be notified if the matter is transmitted to HQE.

MBC's stated policy is appropriate: It should "notify the complainant(s) and subject on all case dispositions . . . ." However, its procedure manuals are inconsistent on this issue and should be clarified.

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to ascertain the gist of the complaint and prepare a comprehensive summary (as permitted by the statute). MBC believes the "summary" option is more efficient. More fundamentally, from a law enforcement perspective, MBC does not believe a complained-of physician should be permitted to know (at least at the outset) the precise details of a complaint about — say — sexual misconduct. When MBC investigates such a complaint, it wants the physician's candid response to the event that is the subject of the complaint as he recalls it. As a matter of sound investigative policy, it is often better to promote spontaneity and candor rather than canned, prepared responses. There is a balance between attempting to "trick" someone who is under investigation and allowing him to prepare canned answers for every single aspect of the complaint. Section 800(c) strikes that balance well, and the Monitor is not prepared to recommend that it be amended.

[142] *See also* Medical Board of California, *Enforcement Operations Manual*, at Ch. 7, § 7.1.

[143] *Id*. at Ch. 8, § 8.7.

[144] *Id*.; see also *id*. at Ch. 7, § 7.1.

9. CCU should regularly review and update its procedure manuals.

CCU's two procedure manuals (the *CCICU Manual* for analysts and the *CCU Medical Consultant Procedure Manual* for medical consultants) were provided to us in October 2003. The *CCICU Manual* had been updated to include the changes made by SB 1950 (Figueroa) (2002), but the *Medical Consultant Procedure Manual* had not. It has since been updated.

C. Initial Recommendations of the MBC Enforcement Monitor

Recommendation #5: CCU should discontinue counting NOIs, NPDB reports, and "change of address citations" as complaints, and accurately report its true complaint total and average complaint processing time. As noted above, CCU has already — in MBC's 2003–04 annual report — discontinued counting NOIs and NPDBs as complaints. CCU should ascertain whether there is any good reason to count "change of address citations" as both complaints and investigations when they are neither; if no sound reason exists, CCU should discontinue counting them as complaints and including them in its calculation of its average complaint processing time.

Recommendation #6: Code of Civil Procedure section 364.1 should be repealed. The "notices of intent" forwarded to MBC under CCP section 364.1 contain very limited information and are generally not helpful to MBC. CCU and MBC district offices now have access to the Civil Index, a more reliable record of all filed civil actions (to which it had no access in 1993 when CCP section 364.1 was enacted).

Recommendation #7: CCU must establish a firm policy on medical records procurement, and HQE must assist CCU in enforcing that policy. CCU spends an average of 66 days procuring medical records in quality of care cases — four times the statutory 15-day period. Physicians ignore lawful requests for records by MBC because they don't think MBC will enforce the law. MBC — including CCU — should stop tolerating delays, enforce existing laws, and utilize the tools available to it to force compliance with medical records laws.

Recommendation #8: MBC and HQE should expand the role of HQE attorneys in CCU. The assignment of a deputy attorney general and supervising investigator to CCU has resulted in enhanced screening of complaints, important modifications to the Citation and Fine Program, and other valuable contributions. MBC and HQE should expand and fund the role of HQE in CCU in compliance with Government Code section 12529 *et seq*. Specifically, HQE should play a much greater role in medical records procurement in CCU (see Recommendation #7 above).

Recommendation #9: CCU should revisit its implementation of the "specialty reviewer" requirement in section 2220.08. MBC's current interpretation of the statute may be overly strict,

is causing a serious and potentially unnecessary delay in the processing of quality of care cases, and is costing the Board time, money, and the use of expert reviewers at the district office level.

Recommendation #10: Section 2220.08 should be amended to permit CCU to refer directly to the field (without specialty review) any new complaint relating to a physician who is the subject of a pending investigation, accusation, or on probation. The investigator, probation monitor, or DAG should be immediately informed of the new complaint and given the option of its immediate referral without specialty review. In addition, consideration should be given to amending section 2220.08 to provide an exception to the specialty reviewer requirement where CCU is unable to locate a specialist after a 30-day good-faith search.

Recommendation #11: The Monitor and all stakeholders in MBC's enforcement program should collaborate to refine the language of section 2220.05's "mandatory case processing priorities" to effectuate the intent of SB 1950 (Figueroa) — "ensur[ing] that physicians . . . representing the greatest threat of harm are identified and disciplined expeditiously."

Recommendation #12: Insurers should be penalized for failure to comply with existing reporting requirements. As recommended by the Joint Legislative Sunset Review Committee in 2002, sections, 801, 801.1, and other provisions requiring insurers and others to file reports of civil malpractice payouts to MBC and to keep medical and other records produced in the legal proceeding leading to those payouts should be amended to include a deterrent-producing penalty for failure to report, failure to file a complete report, and/or failure to produce the records that are required by existing law.

Recommendation #13: Misdemeanor criminal convictions should be reported to MBC. Sections 802.1 and 803.5 should be amended to require physicians to self-report and prosecutors to report misdemeanor criminal convictions to MBC. Misdemeanors are crimes, not bad bedside manner. If they are substantially related to the qualifications, functions, and duties of a physician, they are grounds for disciplinary action and MBC should know about all of them.

Recommendation #14: MBC should educate coroners about their reporting requirements under section 802.5. Coroner reports are a valuable source of information leading to investigations and disciplinary actions, but MBC receives very few reports from them. MBC should design a fact sheet or brochure notifying coroners of the reporting requirement, explaining the importance of coroner reporting and informing them how to obtain the reporting form, and should periodically remind coroners of their reporting responsibility.

Recommendation #15: The Department of Consumer Affairs should — on behalf of all of its regulatory agencies with mandatory reporting requirements — join with the Judicial

Council and other interested stakeholders to design an educational program for courtroom clerks, judges, and public prosecutors to enhance their compliance with the reporting requirements in Business and Professions Code section 800 *et seq*. Many DCA agencies have reporting requirements, and no single agency can or has done an effective job of educating courtroom clerks about their reporting responsibilities. The Department should undertake such an effort on behalf of all of its agencies with reporting requirements, and in fact has begun to dialogue with the Judicial Council on this issue. This educational program should include information on the section 800 reporting requirements and also the important and underutilized mechanism in Penal Code section 23, which permits a DCA agency (or a deputy attorney general representing it) to appear in court during a criminal proceeding against an individual licensed by that agency, and to recommend specific conditions of probation "necessary to promote the interests of justice and protect the interests of the public." The educational program could profitably be undertaken working with the California District Attorneys Association, whose members are required to report certain information to MBC and to alert courtroom clerks that a defendant is a physician, and to judges who supervise those courtroom clerks and preside over criminal matters in which Penal Code section 23 assistance may be offered.

Recommendation #16: The study of peer review authorized in SB 16 (Figueroa) should be funded and conducted as soon as possible. SB 16, which added section 805.2 to authorize an important study of the actual conduct of peer review in California, was enacted in 2001. Governor Davis required MBC to fund the study from its own budget — which was not possible after the hiring freeze and budget cuts starting in October 2001. Senator Figueroa attempted follow-up legislation (SB 2025) authorizing MBC to fund the study in 2002, but the provision was removed from the bill. Section 805 reports are among the most valuable sources of information to the Board about problem physicians — yet fully one-third of them received by MBC in 2003–04 reported peer review actions taken after (and probably due to) MBC disciplinary action. Section 805 is not working as intended, and the study must be funded and conducted — so that section 805 might be amended to conform to the actual conduct of peer review — as soon as possible.

Recommendation #17: MBC's sunset legislation should include a provision banning the inclusion of regulatory gag clauses by licensees of any agency created in Division 2 of the Business and Professions Code. The practice of paying people not to contact regulatory agencies is tantamount to extortion and suborning perjury, and should be banned as against public policy. A California Court of Appeal has already invalidated the use of regulatory gag clauses by physicians, but that ruling has not deterred physicians from continuing to include them in civil settlement agreements — to the great detriment of MBC and the consumers it is required to protect as its "paramount priority."

Recommendation #18: CCU should revisit the staffing allocations of its two sections, and MBC should consider augmenting the staff of this important unit so its analysts are not

overburdened with excessive caseloads and to accommodate the cross-training of analysts to handle important matters expeditiously.

Recommendation #19: CCU should institute a review process for "simple departures" in PC cases — especially in complaints alleging sexual misconduct and drug/alcohol offenses — to ensure that it is not overlooking potential investigations and prosecutions of repeat offenders on grounds of repeated negligent acts.

Recommendation #20: CCU should ensure that subject physicians are notified when complaints are closed or forwarded for investigation. Board policy requires subjects to be notified on all case dispositions. However, its procedure manuals are inconsistent on this issue and should be clarified.

Recommendation #21: CCU should ensure that its policy and procedure manuals are regularly updated to accommodate changes in the law, MBC policy, and CCU structure. Both the DAG and the supervising investigator now assigned to CCU should play a key role in this regular review and revision of all CCU procedure manuals.